Resistance in Small Spaces: Citizen Opposition to Privatisation in Health Care

by

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B.A., University of Waterloo, 1988

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of
MASTER OF ARTS
in the Faculty of Human and Social Development

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University of Victoria

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Abstract

This study identifies the framing of health care debates in a 2001 British Columbia Select Standing Committee on Health public consultation and focuses on citizen resistance to privatisation and profit-making in health care. This Critical Discourse Analysis looks into the midst of participation—represented through talk of presenters who resisted and key texts —exploring how ideas are formulated and revealing the shaping of participation and resistance.

The dominant frame of this debate is narrowed to the small space of fiscalisation, medicalisation, and responsibilisation, where privatisation and profit-making are alleged to be benign, necessary, and inevitable. Despite this small space, presenters in opposition to privatisation and profit-making do resist. Five strategies of resistance are identified: Claiming Authority, Setting the Tone and Establishing a Relationship, Debating the Limits of the Dominant Discourse, Exposing the Manufacturing of the Dominant Framing, and Starting with a Different Premise. This study exposes how this small space was constructed, discovers how inventive resistance can be, and substantiates arguments opposing privatisation and profit-making in health care in Canada.
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Acknowledgments

Writing a thesis often feels like a solitary activity. But with only the briefest of reflection on the process of its writing, I am humbled by the realisation that there were, in fact, many who were by my side.

Thanks to Pamela Moss and Marge Reistsma-Street for the physical space and to Mary Ellen Purkis for the hard ware. Barb Egan, Heather Keenan, and Michelle Connolly, I cannot thank you enough for the encouragement and support you continue to give me and the laughs we shared, may there be more! My two friends who offered their eagle eyes to earlier drafts, Penny Tennenhouse and Carolyn Attridge, I (and future readers) thank you.

To the many wonderful people I have come to know and learn from and with, I am very grateful. My sister scholars, Melody Quinn, Laura Dowhy, Carmela Vezza, and Michele Butot, are just a few who honoured me with their encouragement from the start to finish. Chris Davis and Sally Kimpson became regular listeners to my ponderings and doubts, thank you for offering your suggestions, encouragement, and good friendship beyond measure. Sally, thanks, you already make a great “Dr. Kimpson”. Kathy Teghtsoonian, my scholarly neighbour, our daily drop-ins were appreciated for reasons too numerous to mention. For my many friends who are my chosen family in Victoria, who have watched me revel in grad school and have waited patiently for me to be able to “come out and play”, I am grateful for your encouragement.

In many respects, this thesis is co-authored, for indeed, it arrives at this place with a great deal of guidance from others. Most notably are my fabulous committee members, Marge Reitsma-Street, Michael Prince, and Mary Ellen Purkis from whom I continue to learn a great deal. I thank you for your support, encouragement, never-ending patience, wisdom, commitment to this work, and of course, humour. As my supervisor, Marge, your patience, experience, and guidance was tremendous. Thank you.

Never last and never least, my partner Blair Marshall deserves the most gratitude. It is not easy living with someone who—in close to but not quite middle age—decides she needs to go back to school yet is terrified by the very thought of it. For your patience, constant support, confidence boosting, word-smithing, punctuation lessons, and maintenance of the emotional, technical, and culinary kind, I cannot thank you enough. You’re a keeper.

Catherine van Mossel
Dedication

I dedicate this thesis to the memory of my father, Bert, who, in every aspect of his life, practised social justice, and to my mother, Lorna, who continues to model a strong commitment to social justice and resistance to her family and community and does so with a sense of humour. I thank them both for being my first teachers in critical thinking, without ever suggesting I read Foucault.
Chapter I: Introduction to Inquiry

I was raised in an environment of passion about social justice and it is with little difficulty that I place health care and health care policies under the social justice umbrella. Health care makes the headlines almost daily across Canada and is one of the most important issues of concern for citizens\(^1\) and governments\(^2\). On the minds of many people, the future of Medicare, Canada’s public health care system, occupies considerable time around kitchen tables, editorial board rooms, research meetings, offices of policy makers, and political caucus meetings.

The history of Medicare is not very long. Since the 1940s, there have been attempts to create public systems in various jurisdictions, some successful and others not. Federally, the *Hospital Insurance and Diagnostic Services Act* of 1957 encouraged provinces to establish public medical insurance plans and ensured the people of Canada free access to hospitals and diagnostic services. The federal government committed to use general tax revenue to split the costs with the provinces on roughly a 50-50 basis. The *Medical Care Act* of 1968 provided free access to physician care, again with the federal government covering about one half the cost.\(^3\) In 1984, these two acts were replaced by the *Canada Health Act*. This act remains today as the legislation which determines the criteria and conditions related to insured health care services and which the provinces must follow to receive federal funding. The five criteria under the *Canada Health Act* are: public administration, comprehensiveness, universality, portability, and accessibility.\(^4\)

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Although constitutionally health care is primarily the responsibility of the provinces, funding has always been shared between the provincial and the federal governments. Originally a 50-50 split, the cost-sharing arrangement has changed over the years. The most dramatic change took place in the late 1990s when the federal government announced that the Canada Health and Social Transfer (CHST) would replace previous funding for health and education (The Established Programs Financing) and social assistance and social services (Canada Assistance Plan). The CHST was a single block fund, consisting of both cash and tax transfers to the provincial and territorial governments to fund health, post-secondary education, and social services and social assistance programs.\(^5\) Accompanying the change in federal funding in the mid 1990s was a change in policy direction and service delivery such as the removal of conditions for federal funding. The federal government lost significant control over how the provinces would spend federal monies prompting Moscovitch to predict in 1996 that the changes would allow for a patchwork of programs with varying eligibility criteria, access, and benefits.\(^6\) As part of the 2003 Health Accord, Canada’s First Ministers agreed to restructure the CHST and create separate transfers for health (Canada Health Transfer) and for other social programs (Canada Social Transfer), a change that took effect April, 2004.\(^7\)

The transfer payments from the federal government have been subsequently reduced such that now, the provinces regularly accuse the federal government of contributing about 13-18 percent toward the costs of providing health care today compared to the 50 percent of the 1970s. This accusation is contested by the federal government which reminds the provinces of the value of tax transfers. There is general agreement, however, that the total funding from the federal government has indeed decreased. How the funding formula is calculated, especially with reference to tax


transfers, is rarely part of public conversation yet the decrease in federal funds is a complex issue that is at the heart of considerable controversy between the provincial and federal governments.

It is interesting, too, that this calculation is usually absent given that unsustainability is a mainstay of the dominant discourse. Much of the current debate centres on the sustainability of Canada’s public health care system. An increased role of the private sector, both in terms of delivery and funding, is frequently proposed as a solution to the alleged woes of the system, particularly by those who argue that the public health care system is unsustainable and in a state of crisis. “Private” in health care means several things. The two places it is referred to the most are in terms of delivery and funding. However, privatisation comes in many other forms such as public-private-for-profit partnerships, increased user fees, and delisting of services from public medical insurance plans. Canada’s health care policies are increasingly tied to our relationships with our major trading partner, the United States, and with powerful corporations and trade agreements, all in an increasingly globalised world. These interconnections make us ever more vulnerable to the values and policies of others. The pressure to permit privatisation at various levels is strong and has succeeded in becoming part of public discourse.

I am increasingly alarmed at the idea that our public health care system is heading down the road of privatisation. One need only look to our closest neighbour and one of the richest countries of the world, the United States, to see the injustice resulting from privatisation and profit-making within health care. Health care seems fundamental to quality of life, yet in 1998, in the U.S., fully 16 percent of the population did not have any health care insurance, making their access to health care very difficult. I have read the arguments supporting an increased role of the private sector and I have yet to be convinced by them. Instead, I am struck by the injustice inherent in privatisation and profit-making and am curious how it is that so many Canadians are coming to believe

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they are acceptable and even necessary. Since the idea of a public health care system was conceived, there has been resistance to it from entities such as boards of trade, medical associations, and businesses such as insurance corporations. However, the majority of citizens within Canada continue to view Medicare as a fundamental service. Two Ekos polls from 1999 and 2000 demonstrated that 95 percent of Canadians are committed to strong national standards and 93 percent believe that the federal government should make maintaining our public health care system a high priority. Most Canadians see Medicare as unique in the world and a source of pride. Given that Medicare is an apparent source of pride and appreciation amongst Canadians, I wonder: What is the explanation for this contradiction between the support for Medicare and the willingness to consider privatisation? Where is the opposition to privatisation and profit-making within health care?

I have lived my life with the belief that the health care system in Canada was public. The province of my birth, Saskatchewan, was instrumental in its beginnings, with Tommy Douglas as a key advocate, reformer, and implementer of a public system. That the sustainability of the public system is up for debate is disturbing to me. Some argue that in fact the debate is not new since certain segments of our society have been against Medicare since its inception. Whether the controversy has intensified in the last few years or whether I am just noticing it now, I am not sure. However, I am quite convinced that there is a new air to the discussion, the tone and directions of which are distressing.

British Columbia

The intensity of attention given to health care has raised the level of interest and opinion at every level of society: personal, local, national, and international. In recent

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11 Fuller 19.
years in Canada, there has been a Royal Commission (Shape the Future of Health Care: Commission on the Future of Health Care in Canada), a Senate-initiated commission (The Kirby Report), a report commissioned by the government of Alberta (The Mazankowski Report), and in my province of British Columbia, a public hearing process commissioned by the Government and conducted by the Legislature (The BC Select Standing Committee on Health) and its report (Patients First). In the context of this thesis, I have been challenged to limit myself to one pocket of the many issues of health care and sites of debate and have chosen to focus on the discussions taking place in my own back yard of B.C. In the election in May, 2001 a new government was elected in B.C. that has engaged in a process of making changes to health care. The process of public consultation undertaken by the government has provided a forum to look at how the direction of the changes to health care will be determined.

B.C.'s approach to health care has its own history noteworthy within the broader Canadian context. Commissioned by the governing Social Credit Party in 1990, the Royal Commission on Health Care and Costs produced what became known as the Seaton Report: Closer to Home in 1991. This report was released just after the people of British Columbia had voted in a New Democratic Party Government following 19 years of Social Credit rule. The provincial Ministry of Health responded with the document New Directions for a Healthy British Columbia that recommended major changes such as the recognition of the social determinants of health, decentralisation of health care through the creation of local and regional health boards, the fostering of community participation, and the shifting of services from acute care to community care.13, 14 This report also looked at the management of health care in what was an era of fiscal restraint and federal government reduction in transfer payments justified by an alleged economic downturn. The recommendations in New Directions that required systemic changes, except that of

12 Barlow 21-29.
regionalisation, were put on hold and ultimately shelved. After the election of a new
government in the spring, 2001, the first process looking into health care in B.C. in any
substantive way since New Directions was initiated by the BC Liberals when the BC
Select Standing Committee on Health in 2001 was reactivated to hold public hearings and
write a report. This committee is a standing committee of the legislature and is activated
at the will of the government. It had been dormant for many years.

Changes in the form of increased privatisation were afoot in B.C. long before the
2001 hearing process. It is only in the last few years that I have come to gain an
understanding of what “private” and “privatisation” mean in terms of health care. I
suspect I was like many other Canadians who presumed that our system was completely
public in that I did not realise the extent the private sector played along side Medicare. In
the last decade, the number of private-for-profit services such as private surgical clinics
has risen in B.C. So, too, has private funding such as increased user fees and the private
purchase of private services. I became aware of private-for-profit medical services only
because I knew someone who worked for the Minister of Health under the NDP. I was
surprised to discover that there were profit-making businesses doing knee surgery, for
example, and I was not aware of much opposition to their existence.

The words of the BC Liberal Party during the provincial election campaign of
2001 decried the approach to health care in the 1990s and promised to “put patient care
first”. After winning an unprecedented majority in May, 2001, the Liberals reactivated
the Legislature’s Select Standing Committee on Health and initiated a public consultation
process in September, 2001. It is the site of this consultation process that I have situated
my research.

When I embarked on this research— indeed, when I participated in the public
hearing process—I assumed that the majority of people participating would share my
view opposing any privatisation in health care in contrast to the government, which
seemed to be supportive. With this assumption in mind, I pursued what I thought would
be research that could prove my assumption correct. In the midst of thinking and writing,
I spent half a day in the committee room of the B.C. Legislature thumbing through the
written submissions. There were 750 submissions, an impossible number to read and analyse thoroughly. However, I skimmed the contents of about 25 written submissions and was completely surprised by what I read. It appeared to me that there was a significant willingness to embrace the committee’s interest in an increased role of the private sector in a parallel public-private system as well as emphasis on personal responsibility. I had to sit back and think about how this discourse had become so convincing in B.C. at this time. It was contrary to surveys done across the country where people generally spoke in favour of a public system. Yet it fit with the reality that private clinics were entering the system in B.C. with little or no fanfare. Thus, understanding the framing of the discourse that was dominant in the consultation and exploring attempts to counter it became all the more appealing as a meaningful focus of inquiry. Perhaps there are lessons on counter-framing to be learned and taken forward into further social action.

There is a sizeable literature on public participation and consultation and, in Canada, Royal Commissions and most is reflective, comparing output with input, from a hindsight perspective: how did participants experience their involvement? How did the end result reflect their participation? What ideas and policies derive from the process? My inquiry takes a different approach. I intend to look at the “in the midst” of participation by delving into what happens to participation in the moment and explore how ideas get formulated. In particular, I intend to examine participation when it is in opposition to the dominant framing. Through a critical discourse analysis, the process of discourse production and reproduction, the narrowing of the framing of the debate, and the resistance to it will become evident.

This thesis is driven by my interest in understanding how privatisation and profit-making has increased so dramatically in Canada’s health care system and locating and understanding the opposition to this momentum. It reflects a process: of inquiry, of

16 The emphasis on personal responsibility becomes evident in the analysis of the dominant framing.
17 Barlow 21.
examination, of interpretation. In a sense, it is an unrolling of ideas, understandings, and further questions. It is through this process of “the doing of” research that the concrete nature and focus of my inquiry has become clear. The purpose of this study is to explore a public consultation process to identify the framing of the debates within health care and examine citizen engagement with resistance to the privatisation of health care.

The questions I wanted to answer also became clear in the doing: as I read the literature, as I collected and read the data, and as I engaged in data interpretation. Continuous reflection upon my interests, my conceptual framework, and my methodological approach contributed to this clarity. As such, the questions I answered became evident only in the answering:

What are the discourses currently framing the debate around health care and how do these discourses operate? What strategies are used to invoke these discourses and framings?

How do citizens engage in opposition within this framing? What are the strategies for opposition? Is there a relationship between framing health care in particular ways and the possibilities for being a citizen and for opposing?

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Chapter 2: Context and Conceptual Framework

The purpose of this inquiry is to explore a public consultation process to identify the discourses framing the debates in health care and examine citizen engagement with resistance to the privatisation of health care. Within the context of privatisation and profit-making in health care, I am guided by a conceptual framework consisting of the key concepts of framing, public consultation and participation, and resistance and power. An obvious omission in this chapter is the concept of discourse, which I take up in the methodology chapter.

Key to my inquiry is the concept of framing, both dominant- and counter-, which originated with Goffman and has been taken up and developed by those interested in social movements. Goffman defines “frames” as principles of organization which govern the subjective meaning we assign to social events.¹ Through ongoing theorising, frames have come to be understood as basic structures that guide the perception and representation of reality; they select, shape, and support particular events, ideas, or parts of reality at the expense of others, making some aspects more meaningful, thus more noticeable.², ³ According to Entman, frames define problems; diagnose their causes usually in terms of common cultural values; make moral judgments and assessments; and suggest remedies or treatments for the problem along with predicted effects.⁴ Cultural symbols, images, and arguments are organised in particular ways to affect particular understandings of what is at stake and what are the consequences of various actions. Issues that are structured, defined, and solved within a particular framing influence what will be considered factual and how these facts lead to normative prescriptions for action.⁵

⁵ Fischer 144.
"Through the frame's link to familiar cultural symbols, both material and discursive, communication is not only facilitated, it is literally made possible."6

I characterise dominant framing as the hegemonic assumptions that frame and thus shape the debates taken up in the context of the BC Select Standing Committee on Health public hearing process. Hegemony is the power of persuasion as opposed to power of coercion whereby particular moral, political, or cultural beliefs, values, and practices are proposed to be the natural order, as common sense and desirable.7 Enticing us to look at things in a particular way, the dominant framing is represented in this inquiry in three specifically chosen texts but evidenced elsewhere such as media reports and other commissioned reports. I demonstrate that this framing is dominated by various discourses that, drawn on collectively, constitute what I am referring to as the "dominant discourse". Because I am interested in citizen engagement with resistance during the hearings, I am looking for strategies that attempt to counter the dominant framing, the creation of a counter frame. I use the word "strategy" to mean a method for achieving a specific objective or goal; a plan, action, or art of getting a message across. Jackson states: "a ‘strategy’ implies at least some degree of deliberation rather than an idiom that is routinely and unreflectively employed."8

It is in the context of my concern about the increase in privatisation and profit-making in health care that I explore the substantive concepts of public consultation and participation, and resistance. These concepts provide the conceptual framework for my research.

**Context: Privatisation and Profit-making in Health Care**

The issues of privatisation and profit-making is at the heart of this inquiry as it is the rise of and resistance to them that is of interest to me. The split between public and private, in its various manifestations, has been a controversial issue since the first

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6 Fischer 144.
8 Jackson 59.
attempts at introducing a public health care system in Canada\(^9\),\(^10\) and has received increasing attention in recent years, as seen by the extent of media coverage and public and political debates. Among the current debates at the fore, profit-making in health care and access according to ability to pay are ethical in nature, very much issues of social justice.

The concept of privatisation manifests itself in a variety of ways. In terms of delivery, privatisation suggests that facilities or services are established and administered by the private sector as opposed to the government, the public sector. Examples of private ownership and operation are private surgical clinics (some with specialisation such as orthopaedic surgery or cataracts), diagnostic services (for example, MRIs\(^11\), laboratory tests), rehabilitation services (for example, physical therapy, occupational therapy), pharmaceuticals, optometry, and some home care and long term care. Regardless of whether the funding comes from the public purse or from a private purse such as an individual or private health insurance plan, if services are delivered outside of government by people whose business it is to provide such services, they are privately delivered services.

The meaning of privatisation in terms of delivery, however, can be confusing. If one assumes that only facilities and services administered by the government are considered public, then included in the private sector are some hospitals run by not-for-profit organisations, physicians in private practice, community health centres, and other not-for-profit providers of services such as home care and long term care who have contracts with the government to deliver these services but are independent from government management. Fuller\(^12\) points out that although the majority of hospitals—95 percent in 1997—are non-profit, they are still considered private because they are owned and/or operated by private societies, voluntary organisations, community boards, or municipalities. With the introduction of regionalisation and increased provincial control over health authorities, hospitals are more likely to be the responsibility of government

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\(^9\) Barlow 4-20.
\(^10\) Fuller 12-26.
\(^11\) Magnetic Resonance Imaging
and thus, categorised as public. Administrators are, however, able\textsuperscript{13} to partner with private enterprise and contract out services to the private sector if they choose, as can community-based services such as community health centres.

Services that are based on the principle of not-for-profit and receive their service delivery funding from the government are typically included in the public service delivery sector. Boards of Directors, members, and other stakeholders are responsible to a mission of serving the public good. Making a profit is not a requirement. Services that are delivered by a for-profit business ultimately have profit as a primary goal.

Another component of privatisation is the funding or the purchaser of a service. Public funding is from government health insurance plans that are paid for with tax dollars—the public purse—and in three provinces also premiums, a form of tax. Any purchasing of services with dollars other than from public medical insurance plans or direct government funding is considered private. Included is the private purchasing of privately administered services (as mentioned above) that were never covered or have been de-listed from public medical insurance plans; private purchasing of services available in both the public and private sectors, such as cataract surgery or diagnostic testing; private purchasing of medical insurance that covers particular services both within hospitals and in the community\textsuperscript{14}; user fees; means tests; and eligibility criteria. The source of private funding is individuals or private insurance, not public funds.

Whether the delivery is public or private, funding can be either public or private. There are services that are either publicly or privately delivered that may be partially funded through public funds and partially through private funds. Table 1 attempts to represent the split between public and private. While such a diagram is useful, it does not do justice to the complexities of privatisation, including the implications of each quadrant. An example of its complex nature is the placement of physicians who are largely paid for out of the public purse but, unless they are salaried, are in private practice and run a business.

\textsuperscript{12} Fuller 15, 226.
\textsuperscript{13} and even encouraged to as a means to come in under budget
\textsuperscript{14} According to Fuller, in 1996, 12.3 percent of Canadian hospital revenues are from private sources such as private pay patients and private insurance. Fuller 227.
Table 1: Delivery and Funding of Health Care in Canada

<table>
<thead>
<tr>
<th>Source of Funds for Health Care</th>
<th>Public Delivery</th>
<th>Private Delivery</th>
</tr>
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<tbody>
<tr>
<td><strong>Public Payer</strong>&lt;br&gt;Through tax dollars</td>
<td>Services paid by public insurance plans or government directly&lt;br&gt;Services administered and delivered by government or not-for-profit organisations with government funding&lt;br&gt;E.g., hospitals, community health centres</td>
<td>Services paid by public insurance plans or government directly&lt;br&gt;Services delivered by private organisations&lt;br&gt;E.g., out of hospital diagnostic services such as laboratories, contracted-out services such as housekeeping in hospitals</td>
</tr>
<tr>
<td><strong>Private Payer</strong>&lt;br&gt;Through individuals or private insurance</td>
<td>Services paid by individuals or private insurance plans&lt;br&gt;Services administered and delivered by government or not-for-profit organisations&lt;br&gt;E.g., some home support, some surgeries such as cataract</td>
<td>Services paid by individuals or private insurance plans&lt;br&gt;Services administered and delivered by private organisations&lt;br&gt;E.g., optometrists, pharmaceuticals, some long-term care, privately purchased surgery</td>
</tr>
<tr>
<td></td>
<td>There are both public and private providers of services that are paid partially by public funds, partially by private funds such as user fees.&lt;br&gt;E.g. Some home support, physical therapy out of hospitals, private surgical clinics</td>
<td></td>
</tr>
</tbody>
</table>

The debates about the potential role of private health care in the Canadian health care system are confusing and frequently misleading. Regular arguments in favour of increased privatisation ignore the complexities and the implications of privatisation. Powerful organisations such as the National Citizens’ Coalition, the Fraser Institute, chambers of commerce, and boards of trade have advocated for free enterprise and a market-driven model, even if profit-based, within health care.  

Specifically, they argue that Canadians should be able to spend their own money on their own health care, independent of government; they should be able to buy the health services of their choosing rather than being limited to government-monopolised services. They portray the issue as a matter of choice. Proponents refer to the unsustainability of our public system.

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15 Barlow 21-26.
16 Fuller 19.
for which private deliverers of service would free up greatly needed space, time, and money in the public system.18 Although there is no widely accepted conclusion of what the problems of the Canadian health care system are19 or an understanding of what “health care reform” actually means, the simplicity of arguments in favour of an increased role of the private sector minimises inherent complexities and contradictions and portrays it as a simple, logical and responsible proposition that will address problems and enhance the public system.

While proponents of a fiscal crisis suggest that some degree of privatisation will lead to a more cost-effective system, I am convinced by the many compelling arguments that contest the value of privatisation, particularly the for-profit component. For example, there are many studies that dismiss the claims that increased privatisation will lessen the burden on, be more efficient than, or deal with many of the alleged problems of the public system. In their 1999 study, Woolhandler and Himmelstein established that for decades “no peer-reviewed study has found that for-profit hospitals are less expensive [than not-for-profit hospitals]”.20 They also argue that administration costs are higher in for-profit settings because of the need to collect from many private insurance companies and individual patients.21 In a recent issue of the Canadian Medical Association Journal, a collection of Canadian and American researchers conclude that “private for-profit hospitals result in higher payments for care than private not-for-profit hospitals. Evidence

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19 While the specifics of the system and its problems are interesting, how citizens understand the issues and engage within the debate is the focus of my inquiry.


strongly supports a policy of not-for-profit health care delivery at the hospital level.”22 As Woolhandler and Himmelstein say:

“Investor-owned hospitals are profit maximizers, not cost minimizers. Strategies that bolster profitability often worsen efficiency and drive up costs. [. . .] (M)eeting community needs often threatens profitability. [. . .] Behind false claims of efficiency lies a much uglier truth. Investor-owned care embodies a new value system that severs the community roots and Samaritan traditions of hospitals, makes physicians and nurses into instruments of investors, and views patients as commodities. Investor ownership marks the triumph of greed.”23

Taft and Steward24 argue that the availability of private procedures does not reduce waiting time for those on public wait lists, quoting two studies of cataract surgeries in Alberta25 and Winnipeg26. They conclude that patients needing cataract surgery wait the longest in communities where all surgeries are done in private facilities and wait the least amount of time in communities in which all cataract surgeries are performed in public facilities. They also conclude that waiting times were twice as long for surgeons who practiced in both public and private settings as for those who practiced only in public settings. Additionally, surgeons typically billed extra for patients who received surgery in private facilities. These studies demonstrate that parallel public–private systems are the worst possible scenario.

There is great admiration throughout the world for the advanced science, technology, and practice of American medicine. However, the benefits of American medicine are available only to those with access to the health care system. The American

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23 Woolhandler and Himmelstein “Costs of Care and Administration at For-Profit”
26 Manitoba Centre for Health Policy and Evaluation in Taft and Steward 97-98.
College of Physicians refers to The Census Bureau of the United States, which estimates that 44.3 million people in the United States, or 16.3 percent of the population, had no health insurance in 1998—an increase of about 1 million people since 1997. The health outcomes for people who are uninsured are poor: they experience higher mortality, especially in-hospital, and require more unnecessary hospitalisation and emergency care than insured people. They are less likely to have regular care, more likely to delay seeking care, and are less likely to use preventative services than those who are insured. A quick analysis of those 44.3 million people suggests they are people who live close to the margins or who feel disenfranchised. In a country with parallel public and private systems, not everyone can afford to buy good care and some cannot afford to buy any care at all.

According to a COMPAS Inc. poll published in the National Post November 2001, Canadians “reject private-sector solutions to the system’s problems”. Many Canadians regularly express their valuing of public Medicare and typically reject the involvement of the private sector. Yet, regardless of the support for a public system, the reality is that after hospitals, the second largest expenditure in health care is on pharmaceuticals. The pharmaceutical industry is entirely private. The third largest cost is for physicians, most of whom are essentially in private business, certainly private practice. According to Armstrong, while hospitals consume most of the health care dollars, their percentage of all health spending is down from 45 percent in 1975 to 33 percent in 1999 in part due to the cutbacks in publicly funded health spending. Drug costs have risen from eight percent of health costs in 1975 to 15 percent in 1999 and this figure—only for drugs prescribed outside of hospitals—is considerably more than is spent on physicians. Furthermore, 30 percent of all the dollars spent on health care in Canada is spent privately through such mechanisms as private insurance user fees and the

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28 Barlow 20.
29 Barlow 20.
private purchasing of services such as medication, optometry, physical therapy, and home care.32, 33

In B.C. and elsewhere, public-private partnerships are touted by their supporters as ways to provide buildings or equipment without requiring the initial outlay of funds by the government.34 Public-private partnerships, another example of privatisation, allow governments to rent space or equipment or hire employees from the private sector to deliver public services. According to Pollock35, public-private partnerships are more expensive than if government financed a facility itself because the cost of borrowing is higher to the private sector than to government and financing the cost can add up to 40 percent of the total costs. Public dollars go into private-for-profit hands, several times more than if governments had borrowed money and purchased the building or equipment in the first place. The use of public-private partnerships also makes the responsibility for investing in health services a local responsibility, a shift away from the concept of equity where all localities are funded and serviced equitably and do not depend on their ability to negotiate deals with the private sector.

Betkowski36 argues for “health care reform” that focuses on communities, such as community health centres or care in the home citing common problems and a need to work together to better address our needs. However, Armstrong et al37 are concerned that with “reform” of this nature, governments are shirking their responsibility by downloading responsibility of service delivery to community-based organisations and

31 Armstrong 9-14.
32 the same services as those increasingly provided by the private sector
households, ultimately mainly women, who have neither the resources nor the support to carry the load. They consider this shift of care away from public institutions to communities and households as a form of privatisation of health care. Player and Pollock agree: “the introduction of eligibility criteria and the shrinking of public provision has made care a private and personal responsibility”. 38

Barlow says this kind of downloading is akin to the downloading of responsibility of the financing and delivery of health care from the federal government to the provinces and territories down to health authorities, all of which facilitates privatisation.39 Accompanying the restraint and decrease in federal funding starting in the 1980s and increasing in the mid 1990s, the federal government gave up to the provinces its right to control how funding was spent with the exception that any monies the provinces chose to spend on health care had to be under the provisions of the Canada Health Act.40 With increased financial responsibility, provinces began looking for and demanding efficiencies. In B.C. today, some health authorities and some not-for-profit service deliverers have contracted out services such as laundry, dietary, and housekeeping claiming the private-for-profit companies offer cheaper services than the hospital’s unionised workers. While many argue that this kind of contracting out is a form of privatisation, it is not in contravention of the Canada Health Act, which stipulates that health insurance plans must be publicly administered but does not require that services be provided on a not-for-profit basis.41 Under the Canada Health Act, the intent of the public administration criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority.42

The reduction of services performed in hospitals due to funding cuts and changes in medical practice have created more spaces for the private sector to offer these services in the community—for profit. For example, out-patient rehabilitation services have seen

39 Barlow 30-31.
41 Armstrong et al 14.
considerable change in the last few years. Fuller contends that the majority of them are now in the hands of for-profit businesses, some American-based. Barlow, in her talk in Victoria in the spring of 2002, was very clear that she believes the federal government has intentionally starved the system to bring about the “fall” of Medicare. As the private-for-profit sector makes inroads into the Canadian system, its grip becomes tighter. Barlow states that under the North American Free Trade Agreement (NAFTA), countries cannot give preferential treatment to a domestic service provider over a foreign service provider allowing for the further infiltration of foreign-owned corporations into the Canadian market. That Canada has allowed health insurance to be discussed at the General Agreement on Trade in Services (GATS) table signifies to Barlow that our public health insurance plans are at risk. Canada’s commitment to a national health care program is further put into question by its export of products and services by Canadian private-for-profit corporations to developing countries, including “expertise”—people who advise other countries on how to increase the role of the private sector in their health care system. Additionally, according to Fuller, rehabilitation companies in Canada are branching out into new services such as surgical and acute care and eliminating small independent not-for-profit service providers through mergers and acquisitions, leading the way to a “cross-border amalgamation of the industry and the creation of an integrated North American market”.

Armstrong et al see the changes in management practices that incorporate private sector business strategies and adopt market rules, thereby treating health care as a commodity to be bought and sold, as another aspect of privatisation already underway. Proponents of these business strategies suggest that they are necessary to protect our

43 Fuller 173-174.
44 Barlow 48.
45 Barlow 63-64.
47 Fuller 174.
48 Armstrong et al. 16-17.
health care system. Gratzer argues that as long as health care is considered “free” patients will misuse it and hospitals will continually be mismanaged. He suggests that if patients had to pay for the services they use, they would not take them for granted. He also suggests business strategies would encourage people to take more responsibility for their own health and health care decisions, something he believes is lacking amongst Canadians. Gratzer’s suggestion contradicts Armstrong et al who argue that, in fact, people are not only being responsible for their health, they are forced to be even more so as they take over care previously done within the health system.

Applying market rules to health care introduces the discourse of marketisation, which has been largely absent from intent of Medicare. Barlow argues that Medicare was fought for because it was “a fundamental right of citizenship”. The paradigm shift to consider health care as a commodity is associated with all manifestations of privatisation. The emphasis on patient responsibility as a necessary component of health care reform and choice as a benefit of health care reform ultimately links to increased privatisation and market values. According to Gratzer, health care should become something for which patients shop around to get the best deal; they will buy that best deal only when they really need it, like “looking for a jacket at the Bay”. Conversely, Brodie contends that in contrast to the postwar ideals of universal, publicly provided services, and social citizenship, the new idea of common good is consistent with market-oriented values such as self-reliance, efficiency, and competition, a problem for her but not for Gratzer. These values are firmly embedded in the discourse of marketisation and neo-liberalism and infiltrate the debates on health, health care, and most notably, “health care reform”.

49 He neglects to say that we do pay through our taxes.
51 Barlow 4.
52 Gratzer 171.
Public Consultation and Participation

The concept of personal responsibility is present in most debates on health care. Gratzer’s assertion—that if Canadians had to pay for their health care, they would be more responsible—hints at his belief that Canadians are not being responsible enough in looking after their own health and accessing the health care system. This concept is also prevalent in discussion on ways to address changes to the system. In speaking about “the promotion of an enterprise culture”, Burchell coins the phrase “responsibilization”:

...‘offering’ individuals and collectivities active involvement in action to resolve the kind of issues hitherto held to be the responsibility of authorized governmental agencies...the price of this involvement is that they must assume active responsibility for these activities, both for carrying them out and, of course, for their outcomes, and in so doing they are required to conduct themselves in accordance with the appropriate (or approved) model of action. This might be described as a new form of ‘responsibilization’ corresponding to the new forms in which the governed are encouraged, freely and rationally, to conduct themselves.54

The notion of responsibilization provides a connection between the concepts of privatisation and participation, for indeed, personal responsibility is a value common to both. Peterson and Lupton talk about the “participatory imperative”, where participation is no longer merely a right but a duty.55 The trend to use public consultation as a way to seek participation in public policy direction is on the increase. Scholars, researchers, and community activists have theorised the need for, and the role of, community participation in decision-making of public policy. Variably called community, public, citizen, or consumer56 participation, it is touted as a valued concept integral to a democratic society,57 proclaimed as a tool for ensuring that people’s demands are heard and that services are responsive to needs.58

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56 All terms used interchangeably in the literature, the distinctions to be noted further on in the paper.
initiatives and scholarly analysis of these kinds of initiatives, Persons concludes that improved citizen participation in public policy-making is first, necessary in democratic processes and second, highly desirable.\textsuperscript{59}

In addition to Persons' claim that citizen participation can help to democratise decision-making, there are other factors that allegedly drive the increasing prevalence of this kind of process. They include the desire to:

- increase the public's role in the governance of the health care system;
- respond to the public's insistence on greater responsiveness of health professionals, policy makers, and elected officials to communities;\textsuperscript{60}
- improve the quality of decisions;
- increase the level of education, participation, and engagement of the citizens to, perhaps, create or tap into social capital, community capacity and resources, and social cohesion;\textsuperscript{61, 62}
- link or match health needs and health services;\textsuperscript{63}
- devolve and/or download the responsibility for decisions and accountability from government ministries to regional boards and the like;
- create a sense of self-determination of problems and solutions relevant to local needs;\textsuperscript{64}
- honour the right of people to participate in the planning, implementing and evaluating of their health care system;\textsuperscript{65} and
- redistribute power and equity.\textsuperscript{66}

\begin{itemize}
\item[62] Frankish et al 1472.
\item[63] Frankish et al 1472.
\item[64] Wharf Higgins 277.
\item[65] Frankish et al 1472.
\item[66] Wharf Higgins 277.
\end{itemize}
To support these goals, Hiller, Landenburger, and Natowicz point out that professionals may have technical expertise, but they do not have more qualifications than the rest of the community to make political and moral decisions.67

Parallel with the different ideas about reasons to involve citizens are differing theories on the motivation of decision-makers engaging with such processes. They range from such lofty goals as attempts to:

- build community capacity;
- seek information from the public to make quality, informed, accountable decisions;
- attend to those who use programs or will be affected by policies; and
- close the gap between “us” and “them” — those who plan and provide the services and those who are targeted by them;68

to more cynical agendas such as:

- educating the public so decisions will be acceptable and easier to understand;
- providing information to the public;
- selling ideas;
- achieving consensus or buy-in69, winning them over;
- convincing the public of the value of the decision;
- creating a scenario where the blame for decisions can be shared; or
- diffusing the opposition of protest groups.70

Ableson et al make particular note of the tension between public consultation in order to make informed, meaningful community decisions and public consultation that is, according to one participant in their study, “‘go(ing) through the antics of making the public feel that they have something to do with it’.71 They suggest that as the financial considerations of public policy increase in prominence in public discourse, policy makers who are facing difficult budget decisions and priority-setting are eager to share these

tasks as well as the blame for any cuts with the public.\textsuperscript{72} Public consultation, then, becomes linked with the fiscalisation of issues and policy decisions; decisions will be, at least in part, based on financial considerations and the public is needed to legitimise and share the responsibility for those decisions. \textsuperscript{73}

Aronson suggests that the noble intent of engaging in a public participation process to tie policies and services to consumers' needs represents a "rational, somewhat linear view of the policy-making process".\textsuperscript{74} It ignores the power differentials between those planning, those providing, and those using services. According to Winkler, consultation also sustains and legitimises these power inequities because the process gives the appearance of responsiveness regardless of the outcomes.\textsuperscript{75} In one of her studies, Aronson concludes that the participatory process neglects to follow through with the promise of giving people some control over the policies and practices that influence their lives.\textsuperscript{76}

In her ethnographic study of three community health planning groups in B.C., Wharf Higgins\textsuperscript{77} notes that participants in public consultations and advisory boards tended to be amongst the better educated and were more than likely to be employed in the fields of health and social services than most of the population, not representative of the general public or even a broad base of citizens or the diversity of the community. They tend to be wealthy, educated, confident, skilled, and knowledgeable about the issues at hand. Wharf Higgins also outlines the barriers to participation such as economic and socio-cultural barriers and the often inaccessible, inconvenient, intimidating, and uninviting nature of input-seeking forums. It is questionable whether those who live at the margins and who often feel the negative impact of new policy directions ever make it through the community participation door. Aronson expresses concern that many users of

\textsuperscript{72} Ableson et al, "Obtaining Public Input for Health-Systems Decision-Making" 72.
\textsuperscript{73} James J. Rice and Michael J. Prince, Changing Politics of Canadian Social Policy (Toronto: University of Toronto Press, 2000) 143.
\textsuperscript{74} Aronson, "Giving Consumers a Say in Policy Development" 368.
\textsuperscript{76} Aronson, 1993 367-378.
services who are from disadvantaged or marginalised groups have had little experience articulating their challenges or points of view in public forums and lack the confidence that if they did speak up, their voices would be listened to or taken seriously. Their disadvantage increases when asked to participate in forums outside of their experience or comfort level, such as speaking into microphones, going to fancy hotels, or negotiating unfamiliar situations. Not all people have access to an infrastructure for communication or the freedom to identify themselves as members of particular communities. Also, some people are so impoverished and lacking material resources, they cannot physically get to the meetings and others still may be too ill to attend and speak, despite having valuable knowledge. Concludes Wharf Higgins: “How the opportunity to participate is structured maintains power over people rather than sharing it with them.”

Aronson offers a critique on how participants are often sought out by many policy consultants noting that those “most locked into the official discourse” are often included or invited and those who are expressly in opposition to the official view tend to be excluded. She posits that many who choose to participate often echo the official discourse and repeat what they have heard, particularly comments about fiscal limitations or other ideological statements that put into question the future of current health and social programs. It is as if these participants have come to believe they are part of the problem and are offering up solutions in which they can participate to make things easier for, or fix, the system. This kind of participation is very valuable to policy makers who are interested in a particular policy outcome or direction. It also places the responsibility for certain issues on the backs of citizens and, thus, dilutes the responsibility of decision makers and legislators.

77 Wharf Higgins 277.
78 Aronson, “Giving Consumers a Say in Policy Development” 376.
80 Wharf Higgins 293.
81 Aronson, “Are We Really Listening?” 84.
The goals and intent of public consultations have the attention of researchers. Aronson, in her analysis of a 1991 provincial government report, *Redirection of Long-Term Care and Support Services in Ontario*, determines that the process and mechanics of the consultation were described in detail but the intent was vague: “the collecting of input and advice”.\(^{82}\) Even with the government’s attention to planning details and their stated intent, there were aspects of the process that seemed to restrict participants’ ability to express their experiences and concerns in their own terms.\(^{83}\) Aronson observes what appears to be preset limits to the consultation process and an agenda that was fixed within predetermined bounds. It also appears to her that decisions had been made prior to the consultation process, thereby limiting some possible areas for discussion. She asserted the overall agenda of the government policy she was reviewing was already in place well before any input was sought out from those affected by it. The minister responsible first stated the grounds for reform then asserted the importance of having open and meaningful consultation on this new direction. The irony of this contradictory messaging was noted by participants.

Winkler\(^{84}\) notes that public consultation requires public visibility and a high profile process that feeds the power inequities; it appears to be responsive to the needs of consumers yet affects minimal real change in service. “Ritualistic endeavours designed to shroud an elitist policy-making process in the cloak of democracy”\(^{85}\) is Persons’ summary. As Aronson observes:

> their [public consultation processes] significance may lie in their capacity to legitimize and confirm existing policy-making processes and structures. Possibly, the disparity between their democratizing rhetoric and their generally limited achievements may increase the sense of disenchantment of citizens and consumers who approach them with optimism and expectation. Such disenchantment may serve either to depress and stifle their voices or to anger and galvanize consumers into more active opposition and claims-making.\(^{86}\)

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\(^{82}\) Aronson, “Giving Consumers a Say in Policy Development” 370.

\(^{83}\) Aronson, “Giving Consumers a Say in Policy Development” 370.

\(^{84}\) Winkler 1-2.

\(^{85}\) Persons 121.

\(^{86}\) Aronson, “Giving Consumers a Say in Policy Development” 377.
Church et al maintain that there are two interpretations of Canadian provincial governments’ current use of community participation. The first is that governments are interested in engaging citizen participation based on two assumptions: “citizens want to participate and citizen participation leads to better decision-making”. The second interpretation sees governments co-opting citizens into the larger political goal of downsizing. By attempting to legitimise policy directions that may well be disliked, governments involve the public in the decision-making process, even if that process is highly controlled and constructed. Graham and Phillips argue that this control is necessary to avoid the kind and amount of participation that might place the political agenda at risk. Similarly, Brodie ponders the use of public consultation processes as legitimising instruments of neo-liberal governments which, McGrath and Grant warn, could be misinterpreted for an ideological commitment and shift towards democratising policy-making and planning. By appearing to be genuinely interested in the public’s opinion and promising to set policy accordingly, decision-makers can then rationalise the policies they make and the services they create, redesign, or dismantle. Persons is even more specific: “despite elaborate efforts and processes, the essence of decision-making remains the triumph of conservative, business elites”.

To return to Persons’ conclusions in her study of prevalent community participation initiatives and meta-analysis, she suggests that improved citizen participation in public policy-making is first, necessary in democratic processes and second, highly desirable. Her third conclusion, however, is that it is rarely effective. How

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90 Brodie 140.


92 Persons 121.
effectiveness is defined by various players will, of course, differ. While the orchestraters of consultative processes may think them highly effective, those whose lives will be impacted by policies may agree with Persons, who defines effectiveness as i) decision-making that involves those affected and ii) resulting in decisions that reflect their expressed concerns.93 Peterson and Lupton question the integrity of so-called democratic processes when rational, science-based, expert discourses and bureaucratic structures define and limit the spheres of participation and the subjects who are the participants.94 The sincerity of the oft-articulated goal of improving the democratic decision-making process is questionable if participants do not see themselves reflected in the outcome and do not believe their input affected the final decision.

Thus far, I have used the terms public consultation and public participation, but there is a range of terms used interchangeably and without discrimination: community, public, citizen95, and consumer. The distinctions between them are interesting in how these terms are taken up in the literature, in practice, and in the ideologies they represent or mask. Noteworthy are the terms “consumer” and “consumer input”. The construction of “consumer” in public participation discourse connotes or offers a sense of power. “Consumer input” implies an attempt to right the wrongs of marginalisation, for example, “consumers” of the mental health system. Decision-makers seeking “consumer input” posit an inclusion of people in the decision-making process and maintain that seeking their input will allow them to influence services and the development of policies that directly affect them; the power they hold as “consumers” of these services and policies will allegedly serve to influence policy and service provision. Bolzan and Gale96 challenge this theory by suggesting that referring to those whose input is sought as “consumers” endorses a market ideology and results in a consumerist approach to service provision and policy formation, something they see as problematic. They contend that marginalised people rarely feel included or heard and tend not to trust the mechanisms

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93 Persons 119.
94 Peterson and Lupton 156.
95 even “ordinary citizen”
offered by consumerism.97 They also likely believe they do not have the kind of choice Gratzer says they should have. Others feel manipulated by those with vested interests who are articulate and are positioned within the system as health planners and policy makers, who come to the table with a pre-determined set of ideas on which they say they would like input.98 One of the key arguments against private-for-profit health care delivery and funding in health care is that health care is not a commodity to be traded in the market.99 The simple reference to citizens as consumers, even though in an attempt to appear open to input, puts an ideological bent on the discussion and, arguably, the outcome of the process. Fraser takes this argument one step further by suggesting that consumers are “recipients of predefined services” rather than “agents involved in interpreting their needs and in shaping their life conditions”.100

Central to any discussion on participation and consultation, and indeed, democracy, is the notion of citizenship, which has its own significant and rich literature. Citizenship is a contested and controversial concept101, 102 with multiple perspectives and varied definitions. Nonetheless, most contemporary discussions on citizenship stem from Marshall’s 1949 definition: “a status bestowed on all those who are full member of a community”.103 Citizenship connotes a relationship between the individual and the state,104 along with relations between citizens as individuals and or groups, and is characterised by rights and responsibilities. The ideas of citizenship are interconnected with wider social and cultural issues105 and, thus, are not static. Marshall saw citizenship

97 Bolzan and Gale 364.  
98 Ableson et al 72.  
100 Nancy Fraser, Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory (Minneapolis: University of Minnesota Press, 1989) 174.  
103 Leonard 12.  
104 Leonard 10.  
105 Fitzgerald
as the beginning of equalisation of peoples within society, proposing that it would mitigate the worst excesses of capitalism's 'free market' and would reduce conflict between the classes by the gaining of 'rights' by individuals. For him, citizenship is guaranteed by the equal possession of civil, political, and social rights. Leonard appears to agree, saying that although it is contested, citizenship is a mechanism for regarding all people as equal in a way that is unrelated to and irrespective of social and economic inequalities. However, what remains debateable is whether this mechanism is put to use for this purpose in the many ways citizenship is taken up.

Joseph distinguishes the liberal democratic and the republican traditions. The liberal democratic tradition has emphasised the importance of democratic accountability of governments to citizens who authorise and legitimise the exercise of power through the exercise of their political rights, like the right to vote. In this context, citizenship constitutes a political identity as well as a legal status, which gives equal rights and duties in the public sphere on citizens. On the contrary, the republican tradition assumes the state is a political community that stands for a notion of collective good and in which citizens are equal and active participants in the exercise of political power. An adaptation in neo-republican theories emphasises the need for active participation by citizens in civil society as well as in formal democratic processes. The joining of rights and duties—or responsibilities—speaks to both political and social rights. There is an interdependence of the two.

Brodie's examination of the cultural and discursive transformations that have accompanied post-Keynesian restructuring explores changes in views of citizenship, particularly social citizenship, with regard to welfare. Post-war notions of social citizenship held that poverty was not always an individual's fault and that all citizens had a right to a basic standard of living. Advocates of a public health care system in Canada argued a similar position: all citizens had a basic right to quality health care. However,

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106 Fitzgerald
107 Leonard 9.
109 Brodie 126-140.
according to Brodie, these ideals are under attack by neo-liberal states, which tie social policy to the demands of labour market flexibility and structural competitiveness through the dismantling of the welfare state, by lowering public expectations about citizenship entitlements and the collective provision of social needs. Brodie further argues that neo-liberal governments attempt to make structural inequalities invisible and silence those who attempt to protest them. "This rhetorical strategy conveys the clear message that (it) is up to every 'good individual' to become more flexible and self-reliant and to make few demands on the state."

In a similar vein, Fraser theorises the limits of democracy and takes up Habermas's notion of "the public sphere". She suggests that "public" implies parity where there are no inequalities of statutes or power differentials and all participants are considered as peers. What results from public input, then, is presented as public opinion. Governments use this so-called public opinion as permission or a directive to create policy in a certain direction. Fraser points to the irony: "a discourse of publicity touting accessibility, rationality, and the suspension of status hierarchies is itself deployed as a strategy of distinction". She suggests that for there to be any attempt at parity, governments need to be taking an active role in attempting to reduce social inequalities.

While Fraser is not addressing the issue of participation directly, her points do relate to this broader topic. She contends that the goal of a unified public is not only unrealistic but does not encourage the ideal of "participatory parity" that comes with the "contestation of a plurality of competing publics". Under an assumption of one public sphere, subordinate groups would be less likely to articulate their concerns and interests or even the inequities that exist in the "we" of public opinion than the dominant group, which would have the most say and would be most reflected in the "we".

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110 Brodie 130.
111 Brodie 135.
113 Fraser, "Rethinking the Public Sphere" 74.
114 Fraser, "Rethinking the Public Sphere" 81.
Fraser suggests that the conjecture of a common good (shared by the exploiters and the exploited) is a mystification and should be regarded with suspicion; shedding a new light on the notion that health care is a common good. She further poses the concept of "subaltern counterpublics [. . .] that are parallel discursive arenas where members of subordinated social groups invent and circulate counter-discourses, which in turn permit them to formulate oppositional interpretations of their identities, interests, and needs."\(^{115}\) The result is the opportunity for expanding discursive space, opinion, and contestation as well as the formation of social identities, which counterbalance the participatory privilege held by dominant groups in stratified societies.\(^{116}\)

Young’s\(^ {117}\) view on "public" is akin to Fraser’s as she suggests that the term "public" assumes homogeneity, unitary subjects with a shared point of view that overshadows any difference. While endorsing what she refers to as participatory democracy, she acknowledges that this process excludes or silences some groups.\(^ {118}\) Young argues against a public realm in which citizens disregard their differences or affiliations when discussing a presumed common good or public interest. Rather, she proposes a "heterogeneous public" where there needs to be room for and recognition of diverse voices and perspectives, a "re-politicization of public life".\(^ {119}\) This assertion is in sharp contrast to the message of many orchestraters of consultation processes who attempt to de-politicise the issue at hand, for example, suggestions that health care is not a political issue.

Peterson and Lupton question how participation can really work in contexts "dominated by expertise, competitive individualism, and neo-liberal democratic structures and values" and argue that "the discourse of active citizenship has constrained

\(^{115}\) Fraser, “Rethinking the Public Sphere” 81.

\(^{116}\) Fraser, “Rethinking the Public Sphere” 82 – 83.


\(^{119}\) Young in Mouffe 380.
Many citizens demand to be consulted on policy issues that directly affect them but the process of consultation cannot be entered into blindly or without a critical eye. That there is a plurality of publics implies a plurality of discursive spaces and emerging contesting discourses, which, in turn, calls for a critique of active citizenship and consideration for other venues and formats of political participation and resistance. It is in these instances of contesting discourses that resistance to the dominant discourses is created.

**Resistance and Power**

The concept of power is not lost on researchers taking a critical look at public consultation and participation. That democratising decision-making is frequently the rationale for undertaking public consultation is not so convincing to those who question the values and structures that seem to shape democracies and the apparent lack of appreciation for power differentials in such structures.

Bourdieu believes there is democracy only when there are opposing critical powers, an important point for those critiquing public consultation. Power, or domination, does not exist in isolation but is always in relation. According to Foucault, "there are no relations of power without resistances". That resistance necessarily exists within power relations is fundamental to any analysis of power, especially when the powerful seem to be in control, as many critical of the alleged democracy in public consultation observe. However powerful the dominant become, their power will always be challenged. Working across the disciplines of political science, anthropology, ecology, and cultural studies, Scott argues for the need to theorise power in balance with resistance. "Relations of domination are, at the same time, relations of resistance. . . ."

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120 Peterson and Lupton 146.
Domination does not persist of its own momentum."\textsuperscript{123} Thus, in exploring one I am exploring the other.

Many terms are used in the theorising of political contexts to identify the play and the players within power relations. Scott uses the terms “subordinate” and “dominant elite”; others use “dominant discourse” and “oppositional discourse”. VanderPlaat uses Habermas’s “lifeworld” and “the system”. All of these terms appear to assume a binary approach, an “us” and “them”. I understand the distinction between each and while I use them somewhat interchangeably, I am conscious that it is not always as simple as two opposing sides and that the “them” may sometimes be the “us”. As Foucault suggests, “one should not assume a massive and primal condition of domination, a binary structure with ‘dominators’ on one side and ‘dominated’ on the other, but rather a multiform production of relations of domination”.\textsuperscript{124}

Resistance, dissent, opposition, contestation—conceptually related yet not the same—are manifested in countless ways. Between mass armed revolution and small-scale almost invisible everyday acts of resistance are many sites of resistance where people engage with opposition but do not seek to overthrow social order.\textsuperscript{125} While much resistance is covert and out of view of the public eye, likely much more is done within public spaces. And within these public spaces, resistance can be either overt or covert, thus, much may not be recognisable as resistance. All come with a measure of risk. Frequently, it seems as if the greatest risk, the most bold and public, is taken in places where “freedom” appears the most curtailed. But not exclusively. Even under so-called democracy, contestations that take place in public spaces come with risks.

The conceptualisation of resistance and power is extensive and diverse. It is approached from different angles and speaks to various levels of society from the individual in every day life to international and political organisations. While it is


\textsuperscript{124} Foucault, \textit{Power/Knowledge} 142.

impossible to cover it all in the context of this thesis, it is possible and necessary to understand a range of theoretical approaches and understandings.

Scott bases much of his commentary on his studies of the politics of slavery, serfdom, untouchability, and racial domination which, he argues, represent a large share of “mankind’s melancholy experience” and are means of extorting labour, goods and services from a subject population. Yet much of his theorising is applicable to other contexts. Scott is interested in the sphere of resistance as a way of understanding how the “public transcript” is constructed and maintained and the purposes it serves. He refers to a continuum of discursive locations where transcripts are produced. Power relations exist at locations along this continuum. The more removed from the dominant elite, the more hidden the transcript. And the more hidden from intimidation, the freer people are to act and speak their mind.

I understand “public” to have two meanings in Scott’s work. There is the “public” literally: visible, observable, as opposed to private, out of sight. When out in public, in view of the dominant elite, the transcript is public and subordinates must be aware of their position. Second, I draw a parallel between what Scott refers to as the “public transcript” and what I am referring to as the “dominant framing”; both are “the self-portrait of dominant elites” as they want to be seen, yet are unbalanced, “…a highly partisan and partial narrative”. These public transcripts are produced in what Scott calls “performances” in which both subordinate and elite are participants, the latter willingly and the former under duress. Their purposes are to impress, assert, and naturalise the power of the dominant elites and to act with authority and self-assurance. While attempting to be convincing to subordinates, the dominant elite are also trying to convince themselves. However, they also serve to obscure or “euphemize the dirty linen of their rule”. Public transcripts contribute to and constitute hegemony.

By naturalising their rule, the dominant elites see themselves as ruling on behalf of their subjects, whoever they are. The most public form of political discourse provides

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126 Scott 20-21.
127 Scott 18. Italics in original.
128 Scott 18.
space for a “flattering self-image” that can be interpreted as providing for subjects. In Scott’s example, slave owners could say they provided care, food, housing, and clothing. Within this small “rhetorical” space, slaves could appeal for garden plots, better food, humane treatment etc. Such requests were legitimate and not necessarily seen as outward or bold acts of resistance.

In contrast to the public transcript is what Scott calls the “hidden transcript” where subjects gather “off stage”, beyond the purview of the elites. It is there that freedom of speech can be realised and talk of resistance and action that cannot possibly be spoken in ‘public’ can contribute to an understanding and critique of power. This concept is very similar to Fraser’s “subaltern counter publics”. What is found in the hidden transcript that is not evident in the public transcript, Scott says, is a good indication of “what has been suppressed from power-laden political communication. The hidden transcript is […] the privileged site for nonhegemonic, contrapuntal, dissident, subversive discourse.”

Scott finds there is another politic amongst subordinates, the strategy of “disguise and anonymity that takes place in the public view but is designed to have a double meaning or shields the identity of the actors”. He suggests that this version of the hidden transcript is also always present in the public transcript but needs the attention of interpretation to see it and to avoid a binary understanding of resistance as either open rebellion or buried in the hidden transcript. “A view of politics focused either on what may be command performances of consent or open rebellion represents a far too narrow concept of political life – especially under conditions of tyranny or near-tyranny in which much of the world lives.” Scott calls for a broader look at resistance, including what he calls “infrapolitics”: “low profile forms of resistance that dare not speak in their own name”. Many examples of open rebellion exist today in places where tyranny is blatant and tangible and risk is high. However, resistance is not limited to rebellion and for the majority who are not comfortable considering rebellion as a form of resistance, it is

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129 Scott 25.
130 Scott 19.
131 Scott 20.
important to consider other forms of resistance that do not fit under the heading of rebellion or make the headlines yet constitute active resistance.

According to Scott, any structure of hierarchy comprises and is reinforced by power as a gesture or practice of domination. Power relations include those who dictate and those who are dictated to or, as Foucault says, those who govern and those who are governed, although those subject positions are rarely as delineated as one might think. In Scott’s research context, the survival of those in a subordinate relationship who engage in resistance depends significantly on their mindfulness of their subordination; it is something they best not forget. Their resistance rarely consists of acts of public defiance or open rebellion but has the look of “disguise, deception, and indirection.” What appears to be willing or even fervent consent in power laden situations are just that: appearances. To be anything but covert is to be too risky. Taking at face value deference, something Scott argues is the consequence rather than the creator of a stratified structure where power positions are clearly delineated, denies a deeper understanding of what else might be happening. Deference may be automatic, ingrained acts or a deliberate honouring of someone or something of status. It may also be a calculated display of pretence intended to give an outward impression of compliance. The meaning and motivation of acts of deference will remain unclear “until and unless the power that prompts it weakens” or until their authors can, in the safety of backstage, shed light on their actions.

The dynamics of social action are such that the rules for subordinate groups are usually more restrictive than for dominate elites. Subordinates are more likely to obey the rules requested of them especially further along the continuum toward the public transcript. Rules include permissible discourse but also practical demands and expressions of comfort and ease. Scott thinks of social action as being analogous to a performance. “A convincing performance may require both the suppression or control of feelings that would spoil the performance and the simulation of emotions that are

132 Scott 19.
133 Scott 45.
134 Scott 17.
necessary to the performance.”136 Here, Scott makes the link with power and acting: “Power means not having to act or, more accurately, the capacity to be more negligent and casual about any single performance.”137 Subordinates are on their best behaviour in fear of penalty; the dominants, while also constrained, have fewer rules to follow.

This summary of performance speaks to how power is revealed in the public discourse that exists within social hierarchies. Power is further revealed in the rules established around language. Scott refers to the work of R. Lakoff738 on how language used by men and women can be seen in relation to power. Although referring to males as dominant, her analysis could apply to the power relations of any situation. “In a face-to-face encounter the tone, grammar, and dialect of the dominant (male) is likely to prevail, not to mention that, as in other asymmetrical power relations, the dominant is typically the one who initiates the conversation, controls its direction, and terminates it.” G. Lakoff’s work on language is not dissimilar. His work is based on more contemporary situations than Scott’s, arguing that neo-liberalism controls the political landscape, thus the debates within them, through language. He argues that the right, adherents to neo-liberalism, has realised that individual issues need to be linked to an overall moral and ethical perspective. They have taken concepts such as responsibility, accountability, and efficiency and defined them in ways that fit their conservative values. Thus, these words and concepts have been appropriated to have a new meaning.140 In addition, he argues that even those opposed to neo-liberal concepts usually still use the language and concepts of neo-liberalism even when redefining them. The concepts remain.

Mathieson141 also links language with power. He contends that it is tempting for those opposing the status quo to believe they must not wend too far from it or they will

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135 Scott 25.
136 Scott 28-29.
137 Scott 29. Italics in original.
140 G. Lakoff
not be taken seriously. This assessment demonstrates the power of the dominant elites: those in power determine the language of the debate. He posits that those in opposition to the dominant use the language of the dominant in order to be heard and to ensure they are understood to be in opposition to and by the dominant elite. However, he offers a critique to this practice which is similar to G. Lakoff’s: the more the language of the dominant is used, the more the problem is defined with and in this language. He suggests that when using the language of the dominant discourse in an alternative proposal, the alternative will resemble the status quo too much and not contrast it sufficiently. The dominant elites will continue to determine the parameters of the issue and the debate. Mathieson’s interest, therefore, is how to create a convincing alternative proposal to the status quo that is different but not dismissed.

Bourdieu, in his texts on resisting the marketisation of neo-liberalism, refers to the euphemisms that are inherent in the dominant discourse, making it really just a “repackaging of old ideas of the old capitalists”.142 One of his examples is a company lay off of 2000 workers, referred to in the media as taking a “bold social plan”. The overall message is one of liberation: new ideas that are revolutionary with which no one can possibly disagree. Put forward by politicians, media, and others as inevitable, self-evident, and without opposition, this discourse is repeated and soon taken for granted; it is a “result of a whole labour of symbolic inculcation”143 in which, Bourdieu argues, citizens and media are passive participants and proponents of the discourse are active participants. It gets produced and reproduced until it becomes the dominant discourse evident in everyday language. Bourdieu contends that this work of discourse production is done to “impose as self-evident a neo-liberal view which, essentially, dresses up the most classic presuppositions of conservative thought of all times and all countries in economic rationalizations”.144

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142 Bourdieu 34.
143 Bourdieu 29.
144 Bourdieu 30.
Appeals to progress, reason, and science (mainly economics) positions any opposing thought, discourse, or action as being archaic. VanderPlaat agrees and takes it one step further to suggest that such reliance on scientific discourse and technocratic rationalisation justifies material and social disparities and discursively neutralizes political opposition to the status quo. She calls on emancipatory politics to address this kind of oppression.

In his thinking about subordinates, Scott examines strategies of linguistic deference. He has identified tonal, grammatical, and evasive statements that weaken an emphatic point, citing examples of “hyper-polite” that take the place of a command and rising tones, indicating a request for approval. He also identifies what he calls patterns of “risk-averse” use of language by the powerless – “an attempt to venture as little as possible, to use stock formulas when available, and to avoid taking liberties with language that might give offense”. Scott refers to Khare’s work with untouchables and the identification of evasive strategies, employed when the difference in power was culturally ingrained, such as rhetorical questions and deflection. These strategies, Scott believes, require practice, mastery, and improvisations and operate as “damage-control maneuvers in the face of power”.

These examples of linguistic deference are not merely “performances extracted by power”. They also serve as a protective barrier that Scott believes the dominant have difficulty breaking through. People in subordinate positions develop techniques of resistance and evasion that while active, may appear to be forced upon them. G. Lakoff would agree with Scott that there is a risk that accompanies this evasion: it is acquired at the “cost of contributing to the production of a public transcript that apparently ratifies

145 Bourdieu 35.
147 Scott 30.
148 Scott 30.
150 Scott 32.
the social ideology of the dominant”. G. Lakoff believes that by using the language of the dominant discourse, resisters are perpetuating its constituent concepts. Scott softens the allegation, however, by suggesting that the ratification is only apparent. His reminder of the use of deference may relieve some of Lakoff’s concerns.

Given the realities of power, such performances are sometimes necessary. Scott says “the theatre of power can, by artful practice, become an actual political resource of subordinates”. Taking the appearance of smiles and cooperation as compliance and submission, a performance dictated from above, is to “deny the agency of the actor in appropriating the performance for his own ends. What may look from above like the extraction of a required performance can easily look from below like the artful manipulation of deference and flattery to achieve its own end.” While artful and clever, these acts of resistance are not always successful, Scott suggests. And although ignorant of what is underneath such disguises, the dominant elite frequently know enough to not take them at face value.

Conformity can also be a matter of stifling one’s anger and rage in order to protect one’s self or others. A demonstration of one’s anger can rarely occur safely in the public transcript. It must be made obscure or be expressed off stage to avoid retribution. Thus, there is a risk for those engaging within resistance who do not appear to be “under control”.

Mathieson comes at resistance from a very different standpoint from Scott and Bourdieu in that he is much more directive and offers advice. He bases his commentary on his interest in criminology and activism. Rather than speaking directly to discourse or power relations, he theorises opposition in the context of providing alternatives to the status quo or what I am calling the “dominant framing”. His detailed accounting of his analysis explains how he concludes that an effective convincing alternative to the status

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151 Scott 22. Italics in original.
152 In Scott’s interests, the power of a master over a slave is significant.
153 Theodore Rosengarten, All God’s Dangers: The Life of Nate Shaw in Scott 34.
154 Scott 34.
155 Scott 37.
quo (arguably in any context) lies in the “unfinished”. “Any attempt to change the existing order into something completely finished, a fully formed entity, is destined to fail.”

His advice could be taken into consideration when figuring out how to re-frame the concepts of the dominant discourse. He argues against the temptation to challenge an existing system with a thoroughly thought-out alternative system or proposal. Instead, an alternative proposal must be contradictory to the status quo in terms of means and goals. In order to convince those currently wedded to the status quo that change is necessary, the promoter of the opposition must demonstrate the deficiencies of the status quo and offer an alternative that competes with it. The room for opposition is created through the exposing of the deficiencies of the old system. The ultimate goal, then, is the competing contradiction. Mathieson offers a detailed description of methods of opposition and his explanation for approaches that fail to convince.

*Table 2: Mathieson's Quest for the Alternative*

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<tr>
<th></th>
<th>Foreign</th>
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<tr>
<td>Suggested (incomplete)</td>
<td>Competing contradiction (alternative)</td>
<td>Competing agreement</td>
</tr>
<tr>
<td>Fully formed (complete)</td>
<td>Non-competing contradiction</td>
<td>Non-competing agreement</td>
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As Table 2 depicts, a message needs to be foreign, not part of and clearly different than and in contradiction to that of the current system. It must also be incomplete, not fully formed, therefore, harder to reject out of hand. When an alternative is fully formed, even if competing, the fact that its message is so clearly in opposition to the status quo means it can easily be disregarded by those adhering to the status quo. Even if not fully formed, a non-competing proposal is too similar to the status quo and thus, not enough of an alternative. The competing contradiction or the unfinished contradiction provides the best chance of convincing those who do not think change is necessary to consider an alternative.

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156 Mathieson 13-36.
157 Mathieson 13.
Mathieson suggests that, when those engaging in resistance use the language of the dominant discourse to be heard and taken seriously, their suggested alternative turns from competition into agreement and is no longer a viable alternative. When the contradiction diminishes, the alternative is even less of an alternative because the language of the powerful is usually finished, complete, rather than just suggestive.\textsuperscript{158}

Mathieson contends that it is a temptation for many who are opposed to a particular system or a dominant view in a particular context to believe they must be clear on an idea or come up with a concrete alternative before they express their opposition. But he argues vehemently that “it is vital not to remain silent concerning that which we cannot talk about; it is vital to express the unfinished”.\textsuperscript{159} What creates possibilities is the process of development, not the end result or completion of development. While Mathieson and G. Lakoff discourage the use of the dominant language, neither offer suggestions to resisters as to how to develop their own oppositional language, thus my interest in examining what people actually say when they oppose a dominant script.

“Faced with these mechanisms, what can one do?”\textsuperscript{160} Bourdieu ponders resistance specifically to globalisation and the effects of neo-liberalism. His suggestions do not result from an analysis of individual or even collective acts of resistance but are “high level” in that they speak to an analysis and call for an approach to resistance that is critical and at the systemic and state levels. He challenges citizens to be sceptical of and to resist the “historical inevitability” that adherents of liberalism assert and to create “new forms of collective political work capable of taking note of necessities [. . .] in order to fight them and, where possible, to neutralize them”.\textsuperscript{161} The dominant elite try to naturalise the dominant discourse and resisters try to neutralise, or counter, the dominant discourse. Clearly, the dominant discourse wields a lot of power.

In the context of his suggestion of shifting the gaze within the dominant discourse, Bourdieu proposes an analysis of economic theory, in particular its unspoken limits, which plays a major role in production of the dominant discourse. He advocates a

\textsuperscript{158} Mathieson 19.
\textsuperscript{159} Mathieson 16.
\textsuperscript{160} Bourdieu 39.
conceptual focus on a broad interpretation of costs, particularly given that cost is measured in terms of dollars by economic theorists and their colleagues and social costs are frequently disregarded. He challenges “the critical forces of society” to insist on a calculation of social costs of every decision made for economic purposes. He proposes to “(t)urn its own weapon against the dominant economy” and demonstrate “in the logic of enlightened self-interest” how a strictly economical policy is not economical at all when one considers the social costs. Bourdieu cuts to the chase of a view of neo-liberalism when he proposes that citizens question the economic stance that individualises everything and defines efficiency in narrow, abstract terms and only in relation to financial profitability for investors, again disregarding the impacts on citizens. He calls for an “economics of happiness, which would take note of all profits, individual and collective, material and symbolic, associated with activity [. . .] and also all the material and symbolic costs associated with inactivity or precarious employment”.

Burchell argues that neo-liberalism defines society as the “product of governmental intervention”, an “invention of government” therefore, it “does not really exist”. Bourdieu lobbies for a defence of the state through collaboration between intellectuals, trade unions or associations and other dominated groups in society, especially the state’s social obligation to provide education, health, welfare, and other public programs. He calls for “a ban on backward movement with respect to social gains”, imploring citizens to develop a new internationalism and to create institutions that can resist the forces of the market.

161 Bourdieu 26.
162 Bourdieu 39.
163 Bourdieu 40.
164 Bourdieu 40. Italics in original.
166 Bourdieu 53. Bourdieu describes the state as everything public: education and transportation, for example.
167 Bourdieu 34, 41.
168 Bourdieu 41.
169 Bourdieu specifies Europe as he writes from his place in the state of France.
Bourdieu and Lakoff share a belief that those resisting neo-liberalism are not as advanced in controlling public debate as their opponents, who have mastered the use of the media, public relations consultants, and experts and cornered the dominant discourse. Bourdieu also argues that neo-liberalism is armed with theories that are expounded by “expert” authorities. These theories rationalise the often unjustifiable and package conservative ideals in a cloak of reason and science. He encourages countering theories with “intellectual and cultural weapons”\textsuperscript{170} and reason and science of another order. Bourdieu also calls for collective research: interdisciplinary and international, including social scientists and activists. Social science must be useful to activism. “Our objective is not only to invent responses, but to invent a way of inventing responses, to invent a new form of organisation of the work of contestation and of organization of contestation, of the task of activism.”\textsuperscript{171} Forms of theoretical thought and practical action are needed and they need to consider where the dominant forces are operating and meet them in those places.

Foucault’s interest in the making of and the constitution of the “self” led him to link practices, self, and power. He wanted to understand how the self is constituted through practices and institutions. The nature of practices are revealed less in their description than in their consequences, thus Foucault’s interest in the \textit{effects} of practice and discourse.\textsuperscript{172} These interests resulted in his work on discipline and governmentality, two concepts key to resistance and power. Although he was interested in the links between government, space, and power resulting from new forms of government, Foucault’s notion of governing went beyond the political and ideological realm. He wrote about the techniques of shaping behaviour and ways of being: the shaping, regulating and disciplining of practice. “To govern, in this sense, is to structure the possible field of action of others.”\textsuperscript{173} Discipline is a type of power that consists of a range of techniques, 

\textsuperscript{170} Bourdieu 54.

\textsuperscript{171} Bourdieu 58.


\textsuperscript{173} Chambon 66.
procedures, targets, and levels of applications, the means and technologies that guide behaviour. It restricts unwanted behaviour and shapes wanted behaviour: negative and positive shaping.

In writing about the production and reproduction of the dominant discourse, Bourdieu purports that advocates of the discourse are active participants and citizens and media are passive participants. Foucault has a very different take on participation, which he spells out in governmentality. The concept of governmentality allows us to consider ways in which we discipline ourselves and ways we have become subjects of “government” where we are regulated by power relations. Ranging from “governing the self” to “governing others”, Foucault speaks to “how the modern sovereign state and the modern autonomous individual co-determine each other’s emergence”. Governmentality examines how subjects of governance are actively created and mobilised. It analyses the techniques of government that define, characterise, and incorporate those subjects for particular purposes. These technologies, then, become the instruments of power rather than the source of power relationships. By understanding governmentality, we can come to understand the individual’s capacity for self-determination and its connection to political rule.

Foucault argues for an analysis of the technologies of self as well as the technologies of domination and an integration of the two. The point where individuals are driven by others is tied to the way they conduct themselves. “(G)overning people is not a way to force people to do what the governor wants; it is always a versatile equilibrium.

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175 Bourdieu 29.
178 Mike Raco, “Governmentality, Subject-Building, and the Discourses and Practices of Devolution in the UK” in Transactions of the Institute of British Geographers, (28.1) 75-95
179 Lemke 4.
with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself.”

Foucault identifies three types of power relations: i) strategic games between liberties, ii) government, and iii) domination. Strategic games include actions which modify the possible actions of others through, for example, manipulation, arguments, or exploitation. Government refers to the rational use of technologies that regulate conduct such as the state. Domination is a hierarchal and fixed relationship of power where subordinates have restricted liberties, thus, little room to manoeuvre. Relations of domination, Foucault asserts, are not the source of the power but rather the effects of the technologies of government.

In an in-depth discussion of critiques of neo-liberalism, Lemke argues that the concept of governmentality helps to bridge the dualisms upon which critiques of neo-liberalism are focused: knowledge and power, state and economy, subject and power. “By coupling forms of knowledge, strategies of power and technologies of self it [governmentality] allows for a more comprehensive account of the current political and social transformations, since it makes visible the depth and breadth of processes of domination and exploitation.” One can understand, then, according to Lewis, not just the division between repressive and productive power but, in fact, how one can work through the other to produce particular framings of ideas, relationships, and practices in health care, for example.

Finally, any discussion on resistance and power would be incomplete without a reference to gender. Indeed, only rarely do the aforementioned theorists deal with the issue of gender explicitly. Scott’s “mankind’s melancholy experience” is, in fact, lived

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180 Foucault in Lemke 4.
181 Lemke 5-6.
182 Lemke 3.
183 Lemke 7.
out by women in varying contexts and conditions the world over. Aptheker\textsuperscript{185} takes exception to the theorising of resistance that is defined in terms of opposition and power. She contends that much of the theorising of resistance is done from the standpoint of men—understanding resistance as conceptualised by men. She offers an analysis of resistance from the standpoint of women through a reading of the stories of their daily lives. Believing that most resistance is measured in social changes that result from it, she emphasises the resistance that occurs in the everyday lives of women. Aptheker believes that traditional understandings of resistance assume change will be social rather than individual, political rather than personal, and involving the masses rallying together toward a common goal. She also suggests that there is a whole world of resistance that is outside of any social or political theory or any of these traditional assumptions, resistance that is shaped by the dailiness of women’s lives. And this resistance is not necessarily publicly revolutionary but is still subversively oppositional. It may be cumulative over years and generations of daily, creative, and difficult labours.\textsuperscript{186}

Aptheker proposes a focus on women’s resistance that has emerged from the rigors of daily life.\textsuperscript{187} Resistance is not always a conscious act or oppositional by design. It may be the development of networks, the desire to protect one’s children, or actions that oppose the hardships, oppression, and inequality that many women face daily. Survival drives resistance evident in women’s actions, which support and put meaning into life as they have “walked purposefully in and out of the front door of their lives”\textsuperscript{188}. This kind of survival is a form of resistance akin to Scott’s hidden transcript. Aptheker’s gendered analysis, “what appears as collaboration or accommodation in a masculinist perspective [. . .] may be reinterpreted from women’s standpoint as resistance” may be self-consciously subversive of male will and authority.\textsuperscript{189}

\textsuperscript{185} Bettina Aptheker, “Get Over This Hurdle Because There’s Another One Coming,” in \textit{Tapestries of Life} (Amherst: University of Massachusetts, 1989) 167-230.
\textsuperscript{186} Bettina Aptheker, “Get Over This Hurdle Because There’s Another One Coming,” in \textit{Tapestries of Life} (Amherst: University of Massachusetts, 1989) 173.
\textsuperscript{187} Aptheker 175.
\textsuperscript{189} Aptheker 179-180.
While Bourdieu encourages collaboration between trade unions and other dominated groups, Aptheker reminds us that women have traditionally been marginalised from such organisations where men wage their resistance. It is because women often resist beyond the purview of social theorists that their resistance cannot be analysed in conventional ways. The stories she relays give one example after another of women who demonstrate resistance not in opposition to an obvious power but to their sense and experiences of a world that defies and harms life. Education and the very sharing of stories become tools of resistance for women. Aptheker’s analysis of resistance is a necessary insertion in the countless theories of power and opposition that frame an understanding of resistance.

Summary

The concepts of public consultation and participation, and resistance and power are integral to this inquiry. They come together to provide a framework from which to move forward with this research as they relate to my concern about increasing privatisation and profit-making and my questions about framing and resisting the debates in health care. Yet, this introduction to complex concepts demonstrates that these concepts are contested.

The problematisation of privatisation and profit-making—purported as justifiable and rational responses to the issues facing health care—in the research is cause to explore how they have come to a place of prominence and how people engage with resistance to them. While public consultation is heralded as a democratising process to include people in the process of making decisions that will affect them, critics posit that democracy is not always the goal and not always the outcome. This contradiction compels me to explore why and how people engage with participation, especially to voice their opposition to privatisation in health care, and how they experience this tension. Furthermore, this research is intriguing because of the many possible ways to contemplate and practise resistance, itself a concept that is theorised in multiple ways.

Because there are tensions in the various theoretical views, it seems important to take a thorough look at a location where they are taken up to see the effects of those perspectives. That there is no single understanding of participation and resistance allows
for possibilities beyond what may be considered acceptable. The intent of this thesis to explore engagement with resistance to privatisation and profit-making is all the more compelling given the tensions that exist.
Discourse and Discourse Analysis

As I come to understand the relationships between power, participation, and resistance, the concept of discourse emerges as essential. Discourse is central to this inquiry. Fairclough suggests that discourse is a difficult concept because there are so many contradictory and overlapping interpretations originating from various theoretical and disciplinary perspectives. According to Fowler, who relates discourse to ideology:

'discourse' is speech or writing seen from the point of view of beliefs, values and categories which it embodies; these beliefs etc. constitute a way of looking at the world, an organization or representation of experience—‘ideology’ in the neutral non-pejorative sense. Different modes of discourse encode different representations of experience; and the source of these representations is the communicative context within which the discourse is embedded.

Fairclough differentiates between discourse as understood in linguistics and discourse as understood in social theory. In linguistics, discourse deals with spoken dialogue or written texts, interactions between speaker and addressee or writer and reader, and types of language in particular situations. In contrast, discourse as understood in social theory is evident in the work of Foucault who moves beyond linguistic and communicative analysis by considering discourse in social processes. He views discourse as a way of structuring areas of knowledge and social practices. Mills interprets Foucault as being interested in the structures and rules that produce particular texts more than the texts themselves when he says that discourse is a “regulated practice” that accounts for statements and actions.

Because discourse is seen as affecting the way individuals think and express themselves, it is important in analysing social organisations, social meanings, power

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3 Fairclough 3.
4 Mills 6.
relations, and individual consciousness.\textsuperscript{5, 6} Mills suggests that discourses are organised around practices of exclusion, thus the unsayables. However, according to McHoul and Grace, discourse enables writing, speaking, and thinking as well as constrains.\textsuperscript{7} In Foucault's own words, "(d)iscourse transmits and produces power, it reinforces it, but it also undermines and exposes it, renders it fragile and makes it possible to thwart it."\textsuperscript{8} According to Weedon, language, fundamental to discourse is the "place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested"\textsuperscript{9}.

While discourse is produced through rules governing language and action, it also produces them. Discourses, then, are discernible in particular ways of using language, images, and metaphors. Rather than discourses merely "reflect(ing) social entities and relations, they construct or 'constitute' them; different discourses constitute key entities [be they 'mental illness', 'citizenship' or 'literacy'] in different ways, and position people in different ways as social subjects [e.g., as doctors or patients]".\textsuperscript{10} According to White, discourse is understood to construct categories of people who are then regulated, disciplined, or managed through subject positions; it creates meanings that discipline those who are subjects of and subject to discursive frameworks.\textsuperscript{11} In Weedon's words, "our sense of ourselves, our subjectivity, is constructed".\textsuperscript{12} A set of expectations provides

\textsuperscript{9} Weedon 21.
\textsuperscript{10} Fairclough 4-5.
\textsuperscript{12} Weedon 21. Italics in original.
this subjectivity\textsuperscript{13} and citizens, according to White, participate in their own discipline. In the process of constituting subjects, entities, and relations, discourse also conceals their invention.\textsuperscript{14} Foucault suggests that subjects themselves are the creations of discourse, focusing on the way discourses make people.\textsuperscript{15} For example, the concepts of health and health care come to exist and be understood through the way they are constituted or created in discourse. Similarly, doctors and patients are created and understood through the discourses of health care. “Health” and “patients”, then, come to have particular meanings because of how they appear in language, texts, and social practices.

Rather than thinking of liberalism\textsuperscript{16} as a political ideology or philosophy, White sees it as a “mentality” of governing.\textsuperscript{17} Discourse is the process whereby people come to know the rules that govern their language, their understandings, and their actions. It is disciplinary in nature in that it governs what is thinkable and sayable and, thus, prescribes and penalises what is unthinkable and unsayable. Foucault\textsuperscript{18}, in “Governmentality”, wrote about the roles of discipline and discursive power relations in society. The governmentality approach considers ways in which we discipline ourselves and ways we have become subjects of “government” where we are regulated by power relations.\textsuperscript{19}

Discipline was never more important or more valorized than at the moment when it became important to manage a population; the managing of a population not only concerns the collective mass of phenomena, the level of its aggregate effects, it also implies the management of population in its depths and its details.\textsuperscript{20}

\textsuperscript{13} Notes taken from presentations by Dorothy E. Smith (Jan 15, 2001) and Margaret Wetherell (June 19, 2002)
\textsuperscript{16} or neo-liberalism
\textsuperscript{17} White 61.
\textsuperscript{19} White 59.
\textsuperscript{20} Foucault, “Governmentality” 102.
Collectively, these understandings of discourse provide a context for my inquiry into the framing and resistance of the debates surrounding health care in B.C. The methodology of critical discourse analysis is not limited to the study of language or communication but focuses on the social production and effects of discourse, socio-specific discursive formations. As a critical approach to research, it cuts through “surface appearances” and suggests that “knowledge transformation goes beyond understanding why things are the way they are to studying how they are maintained this way and thus opening up windows for glimpsing alternatives”. Ristock and Pennell use the following definition of discourse analysis: an examination of language and ideologies to assist us in understanding how meanings are produced, allowing us to look at how language serves to uphold oppressive practices. Critical discourse analysis elaborates on Foucault’s study of discourse and is concerned with the ways that power is enacted, reproduced, and resisted through the use of discourse. It defines discourse as a form of “social practice” and helps to identify power and inequality in our social systems. These definitions follow the theory of discourse formulated by Foucault and others.

Framing, fundamental to this thesis, is a discursive mechanism. It guides the representation and perception of reality, selecting, shaping, and supporting particular events, ideas, or parts of reality at the expense of others. It does so through the use of discourse. Cultural symbols, images, and arguments are organised in particular ways to affect particular understandings of what is at stake and what are the consequences of various actions. Particular discourses are drawn upon and thus constitute the dominant framing. Understanding which discourses, particularly dominant or hegemonic discourses, are drawn upon to constitute a framing may explain why and how a particular

21 Fischer 38.
23 Neysmith 104.
frame is adopted or resonates. Discourse analysis, then, is interested in understanding the discursive process of framing to make sense of how particular discourses come to dominate.

In discourse analysis, one analyses material and information as discursive forms. It does not lead to a conclusion of "correct" findings and interpretations but draws attention to the connections between meaning, power, and knowledge. In fact, there is no one "how to" method assigned to this methodology. To understand discourse analysis as a "thing you do" is to misjudge its intent. Rather, discourse analysis is a way of understanding, it is a place where one sits, it is an approach to take to try and make sense. Discourse analysis allows for an understanding of how knowledge is produced and for whose benefit. According to Weedon, "It is only by looking at a discourse in operation, in a specific historical context, that it is possible to see whose interests it serves at a particular moment."

By taking a critical discourse analytical approach to the texts connected to the BC Select Standing Committee on Health, I look beneath the words surrounding and within the debate to see how discourse disciplines, frames, and both spawns and constitutes resistance. There are attempts at countering the discourse or the framing within the discourse, the counter public Fraser talks about. Foucault states:

(One) should not assume a massive and primal condition of domination, a binary structure with 'dominators' on one side and 'dominated' on the other, but rather a multiform production of relations of domination which are partially susceptible of integration into overall strategies...that there are no relations of power without resistances; the latter are all the more

26 Cheryl MacKinnon Oram, The Examination for Discovery In cases of Sexual Violation: A Discourse Analysis Thesis, University of Victoria, 2002, 73.
28 Howarth and Stavrakakis 4.
31 Weedon 111.
real and effective because they are formed right at the point where relations of power are exercised.\textsuperscript{32}

That I am interested in exploring the dominant framing and attempts at countering this framing suggests that I have set up a binary. However, this binary is artificial, as Foucault’s “production of relations of domination” is inherent in both perspectives and becomes evident throughout my inquiry. I draw upon resistance as seen in the production of Scott’s “hidden transcripts”\textsuperscript{33}, Mathieson’s “competing contradictions”\textsuperscript{34}, and Aptheker’s “resistance of dailiness”\textsuperscript{35}, for example, to avoid the abstract and artificial binary and stay close to the production of discourse that enters the debates over privatisation and profit-making in health care in B.C.

\textbf{Methods}

\textit{The Site of Public Consultation}

This research is an examination of participation and the discursive process of framing in the moment, as they are at work. By taking an approach that is neither reflective nor outcome focused, but looks “in the midst of”, I am looking at the beginning of policy development, at how the ideas and knowledges get created that often end up as policy. Masson calls for a discursive analysis of frames—and counter frames—that assesses their consequences, something she suggests is the exception as most analysis is “limited to identifying ‘frames’ without exposing either their content in terms of social meanings or the implications of their institutionalization”.\textsuperscript{36} With this thesis, I hope to add to this exposé.

In May, 2001, The BC Liberals were elected as government, winning 77 of 79 seats after ten years of NDP governance. On August 27, 2001, the Select Standing Committee on Health was reactivated by the Legislative Assembly and received a


\textsuperscript{33} Scott 17-43.

\textsuperscript{34} Mathieson 14.

\textsuperscript{35} Aptheker 175.
mandate to “examine, inquire into and make recommendations with respect to the changes that are necessary to improve the provision of health services in British Columbia, and to ensure that government expenditures on health care services are sustainable.”

It was directed to “conduct broad public consultations across British Columbia”, looking at four specific points:

1. the sustainability of the health care system in its current form and historical rate of spending;
2. immediate and medium term solutions to better plan and manage public health care services, costs and funding pressures;
3. measures to improve and renew the provision of health care services in British Columbia in order to ensure the long term sustainability, accessibility, quality and timeliness of health care services as well as improve health outcomes and the overall health of British Columbians; and
4. other issues as may be determined by the committee.

The committee was an all-party committee, consisting of ten Members of the Legislative Assembly (MLA) from the governing Liberal Party and one MLA from the two-member opposition New Democratic Party. The Special Selection Committee, made up of the house leader and representatives from the BC Liberal caucus, appointed MLAs to sit on the committee and those committee members chose one of their own to be Chair.

A series of public hearings were arranged around the province and calls for written submissions and oral presentations appeared in newspapers across the province. The notice of public hearings was entitled *Strong Medicine for Health Care* and announced: “public consultations to hear your proposals and recommendations for improving the B.C. health care system for patients and their families and ensuring that public health care services can be sustained into the future”. In this notice of public hearing, the committee invited interested individuals and organisations to send written submissions or schedule a presentation for the actual hearing. People wanting to make an oral presentation (called “witnesses”) were invited to request a speaking time from the Office of the Clerk of Committees who scheduled speakers. There were 14 days of hearings in ten locations, the

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36 Masson 65.

proceedings of each recorded by *Hansard*, the official record of debates and hearings of the legislature.

I attended a couple of hours of hearings held in a formal committee room at the B.C. legislature in Victoria. Around a large imposing table sat the committee, a group of men and women who appeared to be middle-class. Although an all-party committee, there were only members of the governing party in attendance. The committee member from the opposition party is one of only two opposition members and as such sits on many committees and cannot attend all meetings. Thus, for all intents and purposes, this committee is a committee of the governing party. Members of the general public sat in rows at one end of the room. Each presenter was called to a microphone that was at the table. I imagine that other hearings would be similarly structured.

According to the report itself, more than 350 people and organisations appeared as witnesses before the committee and over 350 people and organisations contributed written submissions. The report states that “it was the highest volume of submissions received in the history of the legislative committee hearing process”. Several people—including myself—are listed more than once, perhaps in different categories, if they participated in more than one submission. Upon receiving the submissions and the minutes of the public hearings, a researcher employed by the government read them all and wrote a brief summary of each one. A writer was then hired to collate the information and write it up in report form. In its own words, the final report “by virtue of the need for clarity and priority, highlights the leading issues challenging the health care system in B.C. and provides some of the actions the government could take to address these

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38 *Hansard* is the official report of debates in the British Columbia Legislature. Most jurisdictions in the British Commonwealth call their official report of debates “*Hansard*”. *Hansard* is “a full report, in the first person, of all speakers alike, which, though not strictly verbatim, is substantially the verbatim report, with repetitions and redundancies omitted and with obvious mistakes corrected, but which on the other hand leaves out nothing that adds to the meaning of the speech or illustrates the argument.” Legislative Assembly of British Columbia, *Hansard Frequently Asked Questions* 13 Sept. 13, 2004. 26 Oct. 26, 04 <http://www.legis.gov.B.C.ca/hansard/8-5.htm>.

39 This party was not granted official opposition status by the governing party which stated that it lacked the number of members necessary to receive this status and the corresponding financial support.

40 *Patients First* (the report uses two figures for written submissions: more than 350 p 3 and more than 750 p 5)

41 BC Select Standing Committee on Health 5.
concerns". It is unclear who established the priorities. The written submissions are available for public perusal at the Office of the Clerk of Committees at the convenience of the staff. The reports of proceedings of each public hearing were recorded by *Hansard* and are available on the internet.

I have opted to situate my research in this specific site of public consultation. Particular texts will provide insight into the discourses at play to shape and to resist. Texts become central to my analysis but only as a starting place. The discursive texts will provide rich data for interpretation. There are two perspectives I want to explore: i) the dominant framing of the debate and ii) the resistance to, and attempts to counter, this framing. While I used a similar approach to analysis with both perspectives, the process to select the oral presentations and analyse the strategies of resistance required a more elaborate process than was required to choose and analyse the texts representing the dominant framing due, in part, to their accessibility and length.

**Selection of Dominant Framing Texts**

Three texts which most clearly represent the dominant framing were chosen: the BC Liberal Party Campaign Platform of 1991, the invitation to public hearings, and the opening remarks to the public hearings. A place to start to examine the dominant framing, purposefully chosen but artificial in terms of "starting", is the BC Liberal Party Campaign Platform leading up to the spring, 2001 election. Although used as a basis for speech, this document was written as text and posted on the [BC Liberal Party website](http://www.bcliberals.com/Campaign-2001/Platform/New_Era_Healthcare.asp). Its removal months before the next provincial election makes it difficult for people to go back to the BC Liberals' promises and compare them with their accomplishments, on line.

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42 BC Select Standing Committee on Health 5.

43 Although as time goes on, these proceedings become more deeply buried and harder to locate.

submission to the committee. I read this invitation titled *Strong Medicine for Health Care* in the local newspaper in October, 2001 about one week before the hearing geographically closest to me, four and a half months after the government won the provincial election. The last text I examined is that presenting the opening remarks made by the chair of the committee at the opening of the majority of hearings. These remarks were prepared and constant; the same prepared remarks were spoken each time as opposed to spoken off the cuff, as was the dialogue between committee members and witnesses where the text was not prepared in the same way. These remarks demonstrated the place of the dominant discourse within the dominant framing at the time of the hearings and the discourses from which this committee drew to frame the debate and the desired solutions. They set the tone for the hearings themselves and ongoing policy-making.

When reading these three texts (the Campaign Platform, the Invitation to Public Hearings, and the chair’s opening remarks to the hearings), I had the following questions in mind:

- How are the concepts of privatisation and profit-making dealt with?
- What discourses are being drawn upon and how?
- What positions are taken and interests represented?
- How are the dominant discourses evident, produced, and reproduced and how do they contribute to the framing of the debate?

Guided by these questions, the analysis of these texts provides a critical understanding of the framing of the debate to which the people of B.C. were invited to participate.

**Selection of Oral Presenters Resisting Privatisation and Profit-making**

*Strong Medicine for Health Care* invited written submissions and oral presentations to the public hearings. Table 3 outlines nine categories45 I generated to represent the range of those who either presented to the hearings or tendered a written

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45 Accuracy is not guaranteed; I had to surmise categories for some people.
submission to the committee, as individuals, members of a group presentation, or representatives of organisations.46

Table 3: Categories of Presenters at Public Hearings of Select Standing Committee on Health Care, Fall, 2001

<table>
<thead>
<tr>
<th>Category of Representation</th>
<th>Number of Witnesses67</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health professional, health association48</td>
<td>77</td>
</tr>
<tr>
<td>2. Health authority, Ministry of Health, hospital</td>
<td>116</td>
</tr>
<tr>
<td>3. Governing body including advisory councils and Union of B.C. Municipalities</td>
<td>28</td>
</tr>
<tr>
<td>4. Non-profit organisation</td>
<td>144</td>
</tr>
<tr>
<td>5. For-profit business or organisations representing for-profit businesses including, for example, pharmacists, Drug Manufacturers Association</td>
<td>28</td>
</tr>
<tr>
<td>6. Aboriginal</td>
<td>39</td>
</tr>
<tr>
<td>7. Union</td>
<td>19</td>
</tr>
<tr>
<td>8. Education including university, Teachers’ Association</td>
<td>19</td>
</tr>
<tr>
<td>9. Individual with no identifiable affiliation to any other category</td>
<td>43749</td>
</tr>
</tbody>
</table>

It is this total collection of submissions and presentations to the hearings that I used to locate and explore strategies of resistance. I focused on the oral presentations at the public hearings rather than the written submissions because they were recorded by Hansard as proceedings of the hearings and accessible on the internet. Additionally, because I downloaded these texts and have them on my computer screen, I was able to

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46 The total number represented here is considerably higher than 750, likely because several people are listed twice or because a group of people made one collective presentation.

47 “Witness” is the word used in the final report to refer to anyone who made either an oral or written submission.

48 I made a significant yet risky assumption that anyone with the title “Dr” before her or his name was a medical person. This assumption was not made comfortably. However, I did not want to risk putting individuals who had a professional interest and earned their living in health care with individuals who may not. That the title Dr. was left ambiguous in the report may have been intentional, given the apparent priority to a medical understanding of health. But, if the writer or presenter of a submission did not make clear to what her or his title referred, this ambiguity may have been unavoidable.

49 Again, the total is more than 750, I assume because some people like myself are listed more than once if they participated in more than one submission.
use technology to locate expressions of resistance. These texts are accessible now, after the real time they were created, only if one is adept at using the internet. After the sites I had bookmarked were no longer there, I entered into the search engine Google the key phrase “The age of entitlement ended on September 11” to locate them. These texts are no longer at the obvious place on the government website.

Given my interest in privatisation and profit-making in health care, I sought presentations which contest both these concepts and the committee’s framing of the debate. Scott, G. Lakoff, Mathieson, and Bourdieu, amongst others, demonstrate why oppositional discourses are difficult to see and to practise, thus the theoretical interest in this inquiry in uncovering the “hidden transcript”, the strategies of resistance, and the production of a counter framing. I was interested only in presentations that spoke substantively against privatisation and profit-making in Canada’s health care system. I accomplish this task by searching all the transcripts on-line, using the edit/find function of MS Word, for any word relating to the root “privat” and profit. I read the presentations that used these words to determine how the presenters took them up and selected the texts of those presenters who explicitly and substantively spoke against privatisation and profit-making in more than just two or three sentences. I also read the transcripts of any dialogue that took place surrounding the formal presentations such as questions and conversations between presenters and committee members. I do not claim to be looking at transcripts of all those who oppose some or all aspects of the dominant framing. My interests are in privatisation and profit-making within health care, how they come to be positioned as inevitable and logical and how they are reinforced and contested. My purposeful selection ensured that I located and examined those who substantively resisted these concepts.

From a pool of 350 oral presentations to the committee, it is remarkable that I found only 22 presentations that explicitly opposed profit-making and privatisation in a substantive way or tackled the issue head on. This low number may be an indication of

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50 a comment made by the chair of the committee at 11 of the 14 public hearings  
51 One site where this phrase appears is the PEN – L Mailing List Archives Website which has a headline: “Terrorism destroys Canadian Medicare”. Other sites deal with the “uses and abuses” of September 11.  
52 Any word with that as its root would appear such as private, privatise, privatisation.
the effect, the breadth, and depth that the convincingness of the dominant framing. It may also indicate the level of scepticism toward such “participation” processes or the barriers that Aronson and Wharf Higgins note discourage participation.

The transcripts of these 22 oral presentations became my data from which I generated my understandings of the strategies of resistance and counter framing. As such, I was not looking just at a sample of the data but, in fact, an entire population, which is important methodologically. These 22 transcripts provided a reasonable cross-section of presenters representing two genders\(^53\), urban and rural districts, unions, the non-profit sector, for-profit business, health care workers (variously defined), and individual citizens with no other identified affiliation. Neither dis/ability, ethnicity, nor socio-economic status was made evident. Of the nine categories of people who presented or submitted to the committee, seven are represented in my purposeful selection. Missing is representation from governing bodies and for-profit businesses simply because I could not find any transcripts of presenters from these categories which clearly opposed privatisation and profit-making in their presentation. So, while the chosen presenters represent most of the categories of all the presenters to the hearings, they are the sole population who were in opposition to privatisation and profit-making in health care.

In brief, 12 women presented individually as did six men. There was a team of two men, a team of two women, and two groups of women and men. Table 4 outlines the representation from the categories in Table 3. Because some presenters identified in several categories and a couple of presentations had representation from several categories, the total appears larger than 22. Each of the presenters represent—and sometimes speak on behalf of—many other people. One presenter in particular makes specific note that he speaks for thousands of people.

\(^53\) None identified as other than female or male and none identified their sexual orientation.
Table 4: Categories Represented by the Population Resisting the Dominant Framing

<table>
<thead>
<tr>
<th>Category of Presenters</th>
<th>Number of Presenters&lt;sup&gt;54&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. health professional, health association</td>
<td>11</td>
</tr>
<tr>
<td>2. health authority, Ministry of Health, hospital</td>
<td>1 (team of 2 people)</td>
</tr>
<tr>
<td>3. governing body including advisory councils and Union of B.C. Municipalities</td>
<td>0</td>
</tr>
<tr>
<td>4. non-profit organisation</td>
<td>5</td>
</tr>
<tr>
<td>5. For-profit business or organisations representing for-profit businesses including, for example, pharmacists, Drug Manufacturers Association</td>
<td>0</td>
</tr>
<tr>
<td>6. Aboriginal</td>
<td>1</td>
</tr>
<tr>
<td>7. union</td>
<td>5</td>
</tr>
<tr>
<td>8. education including university, Teachers’ Association</td>
<td>1</td>
</tr>
<tr>
<td>9. individual with no identifiable affiliation to any other category</td>
<td>5</td>
</tr>
</tbody>
</table>

Framework to Analyse Resistance in Oral Submissions

While the initial criteria for selecting these presentations was their opposition to privatisation and profit-making, once selected, I looked at all the strategies or techniques of opposition the presenters employed, including approaches that did not deal directly with privatisation and profit-making, the criteria that drew me to their presentation. I read each transcript several times with participation in public consultation and resistance in mind. My reading was also guided by the questions on which my inquiry is centred:

What are the discourses currently framing the debate around health care and how do these discourses operate? What strategies are used to invoke these discourses and framings?

How do citizens engage in opposition within this framing? What are the strategies for opposition? Is there a relationship between framing health

<sup>54</sup> Some presenters identified in several categories, a couple of presentations had representation from several categories thus the number appears higher than 22.
care in particular ways and the possibilities for being a citizen and for opposing?

I developed a list of specific questions to guide me through the reading and the analysis. The framework in Table 5 outlines these questions.

Table 5: Analytical Framework Guiding Analysis of Oppositional Transcripts

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, what are the major points or threads in the submission as they</td>
</tr>
<tr>
<td>relate to the concepts?</td>
</tr>
<tr>
<td>What discourses are being drawn upon and how?</td>
</tr>
<tr>
<td>Where do people come from, what position do they take, from/in what</td>
</tr>
<tr>
<td>context are they writing?</td>
</tr>
<tr>
<td>What angle, strategies, techniques, or approaches do they take with</td>
</tr>
<tr>
<td>respect to my key concepts, specifically their strategies of resistance?</td>
</tr>
<tr>
<td>What do they say, how do they say it? How do they try to get their</td>
</tr>
<tr>
<td>argument across?</td>
</tr>
<tr>
<td>What do their words do? What is the effect of the dominant discourse on</td>
</tr>
<tr>
<td>people and their presentations? How do they make use of the dominant</td>
</tr>
<tr>
<td>discourse to oppose?</td>
</tr>
<tr>
<td>How does the committee respond to presenters?</td>
</tr>
<tr>
<td>Are there any surprises, paradoxes, anomalies, especially as each</td>
</tr>
<tr>
<td>transcript relates to previous ones?</td>
</tr>
</tbody>
</table>

With the framework guiding me, I next used a two-column approach to examine and interpret each transcript. Table 6 is an example of how I organised and examined the data columns. Text of the transcript is in the left-hand column and my initial reading, coding if you will, using the framework of analysis, is in the right hand column. Also in this right hand column are my personal reactions, questions, and ideas inserted in square brackets to distinguish them from the coding. Occasionally, I added a third column to the margin of the printed version by hand with one key word not visible in the table. From these columns, I wrote a summary with headings from the framework.
Table 6: Example of Two-Column Examination of Transcript

<table>
<thead>
<tr>
<th>Presenter:</th>
<th>Chair:</th>
</tr>
</thead>
<tbody>
<tr>
<td>110. (Chair’s first name), we have an extensive written brief, which we’ve submitted to your committee. I’m not going to go through it in detail. Clearly, the message from the people who live in Abbotsford and the valley, the people who live in British Columbia and the people who work in our health care system is that you’ve got to tell your government, “No way” to a private finance initiative in Abbotsford or any other public hospital in British Columbia.</td>
<td>Your words are in Hansard, sir.</td>
</tr>
</tbody>
</table>

111. Chair: Your words are in Hansard, sir.

112. Presenter: That’s good, because until three weeks ago, until we blew the whistle on the plans in the Fraser Valley, no one in Abbotsford knew that there were going to be private financing initiative possibilities with the new hospital in Abbotsford, and that’s shameful. While your committee was going around the province talking about openness and willingness to listen on the part of your party, your party officials, with the health region officials, were working behind closed doors, hiring a private consultant who turns out to be a pusher of private finance initiatives in England—not a very disinterested consultant—to come up with a model of a private finance initiative in Abbotsford. That is shameful.

113. It’s not going to work. It’s going to cost more. You know, we had the advantage of Margaret Thatcher going down this road and making the mistake of building those private hospitals. It takes a little while to do that. There’s ten years of experience in Great Britain as a result of the private hospitals. They’ve just opened this summer. In one, in North Durham, sewage leaks through the ceiling into the pathology department. The pharmacy is next to the morgue so that when patients are getting their prescriptions filled, they see dead bodies go by. The contracting out of the service is such that there’s a dispute about who porters patients. Is it the private company or the hospital? There are no patient porters. The result was that in July of this year the doctor had to call a public paramedic to come off the streets of North Durham to move a patient from the first floor to the third floor. That was the only paramedic on duty in North Durham that night.

The facilitator of the group of presenters, has the last presentation. Speaks very informally to chair by using her first name [so far, he is the only one to do that] Also has a written brief

Summarises the message from his group and says it is the same message from people living in Abbotsford (where the private hospital is rumoured to be built), the people who live in B.C., the people who work in our [he shares ownership] health care system, to give a message to the government: “no way” to a private financed initiative anywhere in B.C.

Chair dismisses presenter’s message and practically defies his request to tell their message to the government when she says “your words are in Hansard, Sir” She counters his calling her by her first name by calling him “sir” [I have not seen that yet]

Presenter goes along with chair “that’s good” as if to play her game and pretend it is not a game, he is being cynical [because I am not convinced he believes her], she has not been convincing, evidence (which he is about to give) shows that the government has its own agenda separate (and in advance) of the findings of this committee.

Wants her that citizens, especially this group of presenters, know what the government is cooking with regard to P3s. “We blew the whistle” Shames the government: “That is shameful” [he is directly shaming the government, making blatant allegations of conspiracy, he is exposing the contradictions in what the committee is saying and what the government is doing [yes, the committee is technically all-party but clearly not in practice], the government has intention of moving forward with private financing but kept those intention secret, did not wait to hear what the public said in these so called consultations [this paragraph is loaded with strategy]

Warning: it’s not going to work, it’s going to cost more Evidence: of the results of Margaret Thatcher’s initiatives, lists problems associated with private hospitals:

Sewage leaks into pathology department
Pharmacy next to morgue
Dispute about who porters patients amongst contracted service providers (one e.g. of a doctor in a private hospital calling on a public paramedic (the only one on duty that night) to transport a patient) [presenter is using anecdotes to make his point. Hard to know if this is a one off e.g. or if this kind of thing happens a lot. He is also drawing on discourse of fear, but perhaps that is a strategy to counter the dominant discourse that such private hospitals are the answer to the crisis in the public system, their own variation of the discourse of fear: fight fear with fear] [his example of fear is compounded, however, with the trade agreement issue: there is no coming back from the kind of fear that accompanies such privatisation].
The transcripts of the population of the 22 presentations were read and interpreted using the process of: i) transcript examination in two columns, ii) summary writing of each transcript, and iii) inspection and comparison of each summary. Each subsequent transcript was chosen because it differed from the previous, a process that assisted in producing contrasting ideas. For example, the first transcript chosen was a single presenter, a woman who has professional and significant personal experience with the health care system, lives in a rural area, and has a specific concern about Pharmacare. The next transcript was of another woman who is First Nations, lives in a city, is a health care worker in a private for-profit facility, and who focuses her presentation on the effects of privatisation and profit-making in health care delivery. Her strategies of resistance are very different than those of the first presenter. For each transcript, I followed the same process of analysis of column coding and summarising to make a comparison of strategies and arguments including their presentation and convincingness, any reaction from the committee, patterns that may be developing, and noteworthy differences. The summaries vary in length from seven to 17 pages depending on the appearance of something not evident in the transcripts I had previously read. They are descriptive, analytical, and comparative. As I had in the column analysis, I also documented my own reactions, thoughts, responses, and queries in square brackets in the summaries. I followed this process and wrote thorough summaries for the first ten presentations. Sensing saturation in the techniques and strategies, I read the remaining presentations in part for confirmation of what I had already discovered, but more importantly, for strategies, patterns, and ideas I had not already seen or those that negated patterns.

The final step after completing the column examination summaries was a reading of all the summaries to identify and describe the range and variety of the techniques and strategies of resistance in the presentations. I then made an assessment of each based on what I thought it meant, what was intended, and how it was used. The last step was to group the techniques into five strategy groupings and again, make a case for how I thought each grouping fit together, how the strategies in them effected, or hoped to effect,
a similar purpose. These five groupings of oppositional strategies are presented in Chapter 5.

**Ethical Considerations and Validity**

Because this research involves documents available in the public domain, I received a Waiver of Ethical Review of Human Research from the University of Victoria Ethics Review Committee on Research and other Activities Involving Human Subjects (see Appendix). I made a commitment to this committee to keep confidential the identity of each person who appears in the transcripts. I have referred to members of the BC Select Standing Committee on Health as “committee member” or “committee chair”. While the names and presentations of the presenters are available on the internet, I did not ask their permission to disclose their identities and stories outside of the hearings, or to examine their presentations in a research study. Thus, I have made every effort to protect their identity. I speak only to their positioning: an individual presenter, one of a group of presenters, or someone who represents a union, works in the health care system, or is a CEO of a health council, for example. In some situations, I have slightly altered the details of their presentation so their identities and stories are not recognisable.

I come to this inquiry with a clear set of beliefs regarding privatisation and profit-making in health care; they are contrary to my values and I do not think there should be a place for them in the Canadian health care system because they create injustice. My opposition is part of what drives my interest; I want to know how resistance to privatisation and profit-making is influenced and can be improved. This bias is not concealed nor does it detract from the importance, value, or usefulness of this research. It may even be beneficial as I come to this inquiry with some personal experience with resistance and knowledge of the debates in health care.

The concepts of validity and rigour are approached and valued in varying ways in qualitative research. As a first-time researcher, I was keen to share my “findings” with experienced researchers not because I questioned my interpretations but because reassurance and additional comments confirmed and deepened my understanding of what I was discovering. I shared a different transcript and my interpretation and summary of it with five experienced researchers, including my committee members, who acted as
independent researchers. They offered suggestions and posed questions that both confirmed and prompted me to clarify my interpretation. Their role validated my methodical approach and assisted me in reading further transcripts.

**Summary**

What appears in hindsight to be a linear process allowed me to be thoughtful and thorough in my analysis and to ensure that I was understanding the richness offered in the texts. The purpose of my inquiry became clear through this process and my conviction of its importance was strengthened. While there is considerable literature on public consultation processes, most is retrospective, evaluating how participants experienced their involvement, how the end result reflected their participation. My inquiry takes a different approach and looks at participation as it happens, in the moment, especially when it is in opposition to the dominant framing. Through a critical analysis, the process of discourse production and reproduction, the narrowing of the framing of the debate, and the resistance to it becomes evident. The following chapters present the findings of this analysis.
Chapter 4: Representations of the Dominant Framing

The BC Select Standing Committee on Health is the site where citizens were invited to share their views on health care. They did not arrive at the hearings to present to a committee void of ideas and beliefs that there were problems, what the problems were, and how they might be solved. By the time of the hearings, it is clear that the committee had a clear understanding of how they understood the issues and the solutions they would consider.

This chapter provides insight into the development of the dominant discourses in B.C. and how they are used to frame the debate and the possibilities of participating within it in the context of the public hearings held by the BC Select Standing Committee on Health in 2001. The three documents used in this inquiry to represent the dominant discourse framing the debate within which citizens resist are: the BC Liberal Party Campaign Platform, the notice of public hearings Strong Medicine for Health Care, and the opening remarks to the hearings. Looking at these texts, it becomes evident that the dominant discourse and framing are produced over time. The committee draws on particular discourses and makes assumptions about how people will interpret this dominant framing.

The BC Liberal Party Campaign Platform

The BC Liberal Campaign Platform document, *A New Era for Health Care*, released prior to the provincial election in May, 2001, has an emphasis that is broad and hopeful. The opening statement summarises the party’s platform regarding health care and presents promises in positive terms: “It’s time to put patient care first. To do that, we must renew public health care, through better management, adequate funding, proper staffing, and sound strategic planning. (Party Leader)” The assumption in these statements is that other (unnamed but presumably the party in power, the NDP) people place patients somewhere other than first, placing other priorities ahead of patients. The BC Liberal Party commits to making a shift for patients from that some other place to

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1 BC Liberal Party, *A New Era for Health Care*. All quotes in the following section are from this document.
first. This sentiment is repeated further in the document: “We are going to put people’s
needs at the centre of health care again”.3 Again, patients are shifted in the priority list
but where the B.C. Liberals are coming from and what “first” looks like are left unsaid.
This shift will be supported by improvements in areas which presumably will make it
possible to put patients first, including renewing public health care and adequate funding.
There is an allegation that funding, staffing, and strategic planning has been inadequate
or mismanaged. The exact definition for “renew public health care” is left unspoken.
However, the tone is positive and reassuring. Although there is a commitment to public
health renewal, there is no comment on privatised health care.

As the platform document unfolds, the tone quickly changes and a discourse of
crisis is drawn upon: “Emergency rooms are overflowing in B.C. We’ve all seen the
pictures. Patients get shuffled from one hospital to the next – if they are lucky enough to
even have a functioning hospital in their community. [. . .] Public health services are
failing patients, even in matters of life and death.”4 These statements are presented as
givens with the assumption that everyone already views them as facts with which they are
in agreement. The words used conjure up images that are no longer hopeful but rather
constitute worry and crisis: shuffled, failing, and life and death, images that are not
desirable in the context of a health care system. Death, in particular, brings with it many
different images. When the health care system is framed as decrepit and deteriorating,
one might wonder if the system itself is the cause of death, in which case it must certainly
be in crisis. “Pictures”, presumably those portrayed in the media, of the terrible state of
health care, where death sometimes occurs because of the failing system, builds on the
negative image. They are used as an important source of evidence that the system is
failing and, when added to the evolving discourse of crisis, hinder the possibility that any
other interpretation or reality is worthy of consideration. As the crisis is made clear,
citizens are meant to be fearful of more of the same if the current government is re-
elected. “Public health services are failing people” may imply that, by contrast, private

2 BC Liberal Party 1.
3 BC Liberal Party 2.
services do not or would not fail people and, therefore, should be expanded as a way to “put patient care first”.

There are references to the creation and the building up of a crisis by the NDP: “(W)e can undo the damage that’s been done by the NDP’s mismanagement over the last decade. [. . . ] Real leadership from the government” will “fix the problem”. The document suggests that citizens can avoid the fear and stem the crisis simply by voting for the BC Liberal Party. Another quote picks up this theme: “Today, 40% of every tax dollar British Columbians send to government goes to health care. These dollars are desperately needed, due to chronic NDP mismanagement and underfunding that left hospitals and regional health districts in the lurch, and left patients without the care they need and deserve.” These two statements are meant to add to the fear of the governing party. But the message about funding is unclear: is the funding enough? Not enough? Or, as is stated further on, perhaps too much? That patients are “left...without” implies that the system abandons people. By placing responsibility solely in the lap of the governing party of the day, these statements make this issue one of party politics. These statements are also the beginning of a fiscalisation of the issue. Fiscalisation occurs when policy debates and decisions are heavily influenced, if not determined, by financial concerns, especially references to the need for deficit reductions and spending restraints. B.C.’s health care problems and perhaps the solutions have a lot to do with (a lack or mismanagement of) money according to this framing. Phrases such as “obsolete”, “undermaintained”, “serious skill shortage”, “urgent need”, “chronic NDP mismanagement and underfunding”, “in the lurch”, “[leaving] patients without the care they need and deserve”, and “reverse the damage” all serve to build upon the discourses of crisis and fear that rise to the dominant position of the framing of the issue.

“Meeting this challenge won’t be easy, but it must be a priority.” This comment provides the first hint that the strategies to meet this challenge may not be too easy. However, the solutions posited in this document appear optimistic, even encouraging

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5 BC Liberal Party 2.
6 BC Liberal Party 4
7 Rice and Prince 143.
with the use of adjectives such as: better, adequate, proper, sound, stable, and sustainable are combined with assurances that the BC Liberal Party will undo the past mistakes and make the system better “again”. Painting the situation as serious, the platform offers solutions depicted in these words that are reassuring, especially when the goal is a laudable “put people’s needs at the centre of health care again”. The crisis will be over, there will be no more cause for fear. All will be better again.

“Sustainable” is a word that is contested and illusive; it is variably defined and understood. Governing bodies often use it to suggest affordability (again, illusive, suggestive of some undefined revenue availability). The promise for “bringing stability back to our health care system with long term funding commitments” adds to an element of conditionality: “A BC Liberal Government will [...] increase future health care funding as economic growth increases government revenues”. With this proviso, the funding may remain or even decrease if revenues and the economy do not grow. This one line negates guarantees of the opening statement (put patients first, renew public health care, and adequate funding, for example) and presents uncertainty as necessary. The future of health care now lies, at least in part, with the state of the economy. The fiscalisation continues.

The many encouraging commitments, including to the Canada Health Act and to renewed public health care, are meant to be supported by a commitment to do things differently than the NDP, who, this document alleges, is responsible for the crisis at hand. By the end of this document, however, the promise of the opening statement has faded slightly to one of tentativeness, dependent on economic conditions, over which, one might assume, the BC Liberals will have no control.

It was this platform, part of a larger campaign platform, on which the BC Liberals fought and won the 2001 election with a massive majority, winning 77 of 79 seats reducing the NDP to a two-member rump. Through the process of framing, it guided the representation and perception of reality in a particular way. The platform did what Entman describes: it framed the problem of health care, made moral judgements and

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8 The fact that governments control revenue and expenditures is omitted.

9 Entman 52.
assessments about what had been done under the previous government and what was at stake, and suggested treatments. This discursive process of framing by the BC Liberals must have had some effect on the electorate who voted them in overwhelmingly. The BC Liberals took their win to be a mandate to act on their election promises.

**Notice of Public Hearings**

Four months after the election, the legislature re-activated the Select Standing Committee on Health which, in turn, embarked on a public consultation process. *Strong Medicine for Health Care*\(^{10}\), the invitation to this process, is citizens' introduction to this committee's framing of what they see as the issue at hand and represents a further development of the dominant framing. A simple play with medical language, the title alone is loaded with meaning. It carries through with one line of the campaign platform "(m)eeting this challenge won't be easy, but it must be a priority." *Strong Medicine for Health Care* is a metaphorical reference that aligns the solutions the committee is looking for with strong medicine. It suggests that the system is very sick and suffering; strong medicine is usually necessary to cure a serious illness. The implication in this document is that the health care system is seriously ill and the treatment necessary must be strong to be effective and, therefore, could be potent, perhaps extreme, maybe even foul tasting. It will not be simple, it may not be easy to swallow, but to be a responsible patient, you will take it. The message of "strong medicine" also privileges a medical and acute care perspective to health care, medicalising the debate.

One could take this metaphor one step further and suggest the medicine for our health care system might have harmful side effects, as medicine often does. The use of the medical metaphor places both the health care system and the patient as objects. The system has become the patient. Given the committee's mandate to fix the system, the implication is that the patient needs fixing, as well.

The notice of public hearing announces that the BC Select Standing Committee on Health is holding public consultations to hear "your proposals and recommendations for improving the B.C. health care system for patients and their families and ensuring that

\(^{10}\) All quotes in this section are from this document.
public health care services can be sustained into the future”. Sustainability remains an issue, confirmed by the next paragraph which establishes the committee’s understanding of the dilemma they are facing and the committee’s job.

The problem is presented as follows: “The B.C. Government now spends in excess of $9 billion a year on our health care system and costs continue to rise. Unrestricted budget growth is not possible.” The notice adds to the crescendo of the crisis discourse. Within this framing, “(t)he Select Standing Committee on Health has been reactivated to help find innovative and workable solutions to protect and improve our public health care system.” Fiscalisation is becoming increasingly prominent, money is the issue. Yet, while the campaign platform said that the previous government provided inadequate funding, the committee is now saying increased funding is not possible. The parameters within which citizens are to consider solutions are becoming clear as well; they must deal with the unrestricted health budget growth. Suggestions that offer “innovative and workable solutions” to reduce budget growth will be considered, not any and all solutions. At this stage, however, the system to which there is a commitment to protect and improve remains public.

The invitation continues to ask of “all interested individuals and organisations several questions:

- What creative and practical short, medium, and long-term initiatives can you propose to address rising costs or to increase efficiencies in the health care system?
- What can the B.C. government do to protect the delivery of public health care services, improve health outcomes and support the overall health of British Columbians, while also controlling rising costs and funding pressures?
- What can the B.C. government do to ensure the long-term sustainability of a B.C. health care system that is based on the principles of accessibility, quality and prompt services delivery?”

All three questions deal with money: rising costs, efficiencies, funding pressures, and sustainability. In contrast to the previous assertion that patients must come first, the patients have now virtually disappeared, or have certainly lost their place of priority. The request is that the solutions must also deal with money. The “adequate funding” that the campaign platform posits as one way to renew public health care has turned into requesting solutions that address rising costs and funding pressures. The issue of money is paramount. The ambiguous commitment of putting patients first is not mentioned. We
see here a further refinement of the construction of the dominant discourses and framing and it has increasingly little to do with the patients and patient care that were front and centre of the campaign platform.

Other debates about B.C. politics occurring in media and citizen discussions at the same time as this hearing process centre on deficits, over spending, and cost controlling in all spheres, all supporting the discourses framing discussions on health care. That this committee draws so soon in its process, in a public statement in an invitation to public consultation, on these discourses suggests that fiscal pressures and crisis are becoming embedded in the dominant framing. As the dominant framing becomes clearer, so, too, do the expectations of citizens presenting proposals and recommendations. These expectations are examples of what philosopher and social critic Foucault calls technologies of domination.

The layout of the notice of public hearing in the newspaper is “Strong Medicine for Health Care” at the top and “It’s your chance to participate” at the bottom. In the middle, a question is posed: WHAT WOULD YOU DO? Peterson, in his critical examination of the new public health, argues that participation is no longer just a right, it has become a duty of the responsible citizen. The insinuation, albeit subtle at this point, is that it is your duty to participate and join in the creation of this strong medicine just as it would be your duty as a responsible patient to take the medicine designed for your illness. It is also your duty, as you do participate, to come up with solutions to the problem as this notice defines it within the parameters provided in the questions. Proposals and recommendations must fit the dominant framing.

Opening Remarks to the Hearings

Of the 14 hearings held throughout B.C., 11 of them are introduced by prepared opening remarks spoken by the chair of the committee. These comments are the final touches to set the stage for the proceedings of the hearings. While the campaign platform provides a more general view of the government's position, the notice of public hearing

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11 Large type in original.
12 Peterson 146.
adds to this position to frame the kind of plans and actions that can be presented by witnesses and taken up as solutions. These opening remarks fine tune the framing.

The opening remarks begin by stating the primary goal of the government: “to save our health care”. Missing is the public before health care that was in place in the campaign platform and the notice of public hearing. This omission is striking, given what follows in the chair’s remarks. It exemplifies how the framing is being gently massaged by its authors and disseminated in public settings. The only time public is mentioned in these comments is to say that Canada “theoretically, has a universal public health care system. [. . .] In practical terms, we currently have a multi-tiered system.” The committee has moved from wanting to renew the public health system of the campaign platform, to wanting to save the public system in the notice of hearing, to suggesting in the opening remarks that a public system really does not exist anyway. The public component of health care is no longer on the agenda to be saved and “sustained into the future”.14

Immediate reference is made to countries that do not claim to have a universal public health care system but have either two or multi-layered systems, for example Britain and the U.S. While the chair recognises “homegrown talent” and “seeks out the expertise, imagination and commitment of British Columbians as we bring the health back into health care”, the suggestion is that the countries referred to have systems that we could or should consider modelling. Given that the public is no longer on the table, modelling these non-public systems is a natural suggestion; the health that is missing from health care need not be public in its governance or funding. And if health is missing (“bring health back”), health care must be ill, which takes us back to the metaphor used in the notice of hearing. The illness will be cured by a strong medicine that questions the legitimacy of public health care.

In contrast to the adequate funding that was deemed by the leader of the BC Liberals to be part of the solution to renew public health care in the campaign platform, the chair of the Select Standing Committee asserts that “simply throwing money at the system has proved to be a dismal failure. We need solutions not rhetoric and certainly not

13 All quotations in this section are from this document.
14 Strong Medicine for Health Care
allegiance to the status quo.’’ She does not say what she thinks the status quo is. “We
need a sound financial foundation on which to build.” The fiscalisation of the issue
maintains its prominence. Solutions that incorporate spending of money will not be
considered.

The construction of the dominant discourse takes a considerable twist with the
introduction of what has come to be known by the phrase “9/11”. As part of the opening
remarks, the following statement was repeated by the committee’s chair at 11 of the 14
public hearings. “The age of entitlement ended on September 11. We can no longer
demand services as our due. We have to accept responsibility along with our rights. Even
patients and their families have responsibilities in using health services prudently.” This
comment is an unmistakable reference to events in the United States on September 11,
2001. The infiltration of the complex and potent discourse associated with these events is
both curious and troubling, one effect of being “best friends” with the most powerful
nation in the world. For many, this discourse is dominated by fear and retaliation; public
discourse surrounding this day focuses, in part, on “the war on terrorism” and security.
While there is a hint of fear of a failing system in the Spring 2001 election campaign
platform, there is now no mistaking the fear factor of September 11 introduced to the
dominant framing. What the “age of entitlement” is or was and how it ended with the
events of that day are not readily clear. The day of September 11 seems to serve as a
justification to remove rights and demand people change their expectations of citizenship,
although what those expectations are is unsaid. One might assume that too many people
have assumed that health care was a right, an assumption the committee chair has just
removed. But why they were removed on that day is anyone’s guess.

This removal of “entitlement” also contradicts a statement of the election
campaign platform:

The provincial government has an obligation to ensure that all British
Columbians get the level and quality of care that they are entitled to under
the Canada Health Act. That means all citizens should have a
comprehensive, publicly administered health care system that ensures high
quality, timely health services are universally available and accessible to
all throughout the province.15

15 BC Liberal Party 25.
While there was a sense of entitlement during the election campaign, it is gone by the time of the hearings. This statement also introduces the discourse of personal responsibility and perhaps irresponsibility. Inherent in these comments is the idea that patients and their families have been too demanding, irresponsible, and unwise in their use of services, perhaps demanding and using more than they deserved. The chair does not specify what responsibilities she is talking about. She may be referring to the responsibility to participate in public consultation processes such as this one, to take strong medicine, and now, to make prudent use of health services. Perhaps, she also refers to the responsibility to have better health, insinuating that if people have poor health, maybe they have not been responsible enough.

“This committee is committed to solutions [...] Health care is not a big-p political issue; it’s a problem facing each and every one of us.” The chair attempts to depoliticise health care, a contradiction to the significant number of references to the NDP being responsible for the current crisis of health care in B.C. in the campaign platform. She is negating the influence of other political decisions on health care. By including herself in “each and every one of us”, the chair attempts to deny the power that she as chair, this committee, and indeed, this government has to make political decisions that will affect citizens. This attempt to depoliticise health care serves to remind witnesses that any solutions they put forth must be non-political, or at least not deal with other political decisions. It seeks to absolve legislators from the decisions they make, their effects, and the responsibility to be part of the solution.

The chair then returns to the fiscalisation of the framing by referring to the dollars that are spent on health care. “Our patients and their families are not receiving the care they are actually paying for through their tax dollars.” This statement comes close to the idea of entitlement (people are not getting what they pay for) which she has earlier refuted. However, it appears as if her intention is to remind citizens at the hearings that the cost of the system is the real issue. That people are not getting what they pay for is a given and is problematic. This comment draws again on the discourse of crisis that is meant to pull on the heart strings of every taxpayer who wants to get the most for her money.
The fact that public has disappeared goes unnoticed. Thus, the introduction of solutions that are contrary to a public system are "hearable" and "discussable". The comments that follow the chair's introduction are in keeping with an absence of public with the reference to the two-tiered health care system in the UK that includes private health insurance and a means test for health care programs. With the UK system mentioned as a system B.C. might consider emulating, the allegiance to a public health care system is gone. Indeed, "in practical terms, we currently have a multi-tiered system. [...] We have reached a point where we need to visit all avenues of health expertise and suggestions, both internal and external, to reach workable solutions." The aforementioned "homegrown talent" will only be considered in the context of the external expertise. It appears that there has already been a merge between homegrown and external practices, according to the chair: "Even my local community newspaper, the Delta Optimist, has started carrying articles on such issues as long-term care insurance to reduce reliance on government."

This statement, however, introduces yet another "problem" that the chair has only alluded to previously and that is reliance on government. This statement reflects the ideology of the government dominating this committee and completes the circle; it is the responsibility of citizens not to rely on the government. They must take the personal responsibility necessary to save our health care. Less reliance will reduce costs, alleviate funding pressures, contribute to long term sustainability of the system, and create efficiencies. If "even [...] the Delta Optimist" has the answer, so must responsible citizens. Burchell's notion of responsibilisation is woven throughout these remarks.

Brodie, a political scientist, argued in 1996 that Canada's social safety net was about to receive a makeover to adapt to the market-based, self reliant, and privatising ideals of the new order. By 2001, the chair of the BC Select Standing Committee on Health confirmed Brodie's suspicion. The chair appeals to citizens to look to countries where a private system plays a significant role in health care as models to emulate. She mentions the already existing private-payer and privately-provided services in Canada.

16 Brodie 131.
17 see Table 1
and she petitions citizens to be less demanding on government. All these actions do more than merely suggest that privatisation is worthy of consideration. No longer can citizens expect to have entitlements, make so-called demands. Responsibility for their individual welfare now rests on each individual’s shoulder. Privatisation is put forward as the way to achieve this new future.

The discipline this committee prescribes to people who have chosen to participate in this public hearing is woven throughout these opening remarks. Presenters are provided the framework for their presentations and as responsible citizens, which they are because they have chosen to participate, they will follow the prescription given them. And they will swallow the prescription for the good health that results from these hearings, the strong medicine indeed. The prescription is being written; the metaphor continues.

Finally, after the first hearing, these remarks are repeated with only a few variations in ten of the 13 subsequent hearings. At another hearing where the chair is absent at the start, she refers to them later, quoting a line from her opening remarks. They are very much a prepared text rather than something spoken in the moment. That they are so prepared and so often repeated suggests they are meant to have a particular effect. They provide more than just clues or context; the chair believes in the importance of her words to establish a perimeter around allowable discussion. In line with Foucault’s understanding of discourse, the dominant discourses and framing provide the process whereby people come to know the rules that govern their language, their understandings, and their actions. Discourse is disciplinary in nature in that it governs what is thinkable and sayable and, thus, prescribes what is unthinkable and unsayable. Foucault’s “technologies”, used to guide or shape behaviour, are becoming increasingly clear. The opening remarks contribute significantly to the shaping of the discussions on health care in B.C. at the hearings. The space has been narrowed, the dominant discourse developed and made clear, and the acceptable solutions laid bare.

Through a critical reading of the three texts representing the dominant framing, I offer evidence of how this framing is constructed and has moved away from the positive, but worried tone of the campaign platform to a post-election emphasis on the fiscal aspects of health care, and has reached the point of the hearing where the rules of
engagement are made clear. The dominating discourses provide the frame in which people are permitted to respond. The dominant framing is limited to fiscalisation, medicalisation, responsibilisation where privatisation and profit-making in health care are alleged to be harmless and benign. It is in this small space of crisis, unsustainability, and irresponsibility that privatisation is being positioned as the logical and inevitable solution.
Chapter 5: Creating a Counter Frame

From a place of critical analysis, I have been able to draw out and expose the restrictions that are inherent in discourse as is evident in the dominant framing of these public hearings. As well as constraining, however, discourse also creates space in which resistance happens. Recalling Foucault, "(d)iscourse transmits and produces power; it reinforces it, but it also undermines and exposes it, renders it fragile and makes it possible to thwart it." The presenters resisting the dominant framing of these hearings are attempting to do as Foucault suggests.

The three texts leading up to the public hearings illustrate the dominant framing in which the public hearings are situated and which shape the resistance to it. Citizens have done what has been asked of them and responded to the invitation in the greatest numbers in the history of the B.C. legislative committee hearing process. Opposed to the privatisation of and profit-making in health care, a small but committed group of citizens have struggled with and in the space created by the dominant discourse to engage in resistance. A critical reading of the transcripts of these presenters provides me with an understanding of what this resistance looks like within the dominant framing.

Public hearings are amongst the most public of transcripts, literally and figuratively. They are open to the public through invitation and there is an expectation to participate. Hearings are also one of the discursive locations where the public transcript is constructed and, indeed, a transcript is produced, again, both literally and figuratively. I appreciate Scott's contention that understanding resistance as either "command performances of consent or open rebellion" is too narrow. He encourages looking in between these two places to get an idea of what is possible and what is practical under certain situations. The public hearings of consultation held by the BC Select Standing Committee on Health are such a space in between and provide a context in which

2 BC Select Standing Committee of Health Care 5.
3 Scott 20.
4 Scott 19-20.
resistance can be considered. By a particular reading of the transcripts, acts of resistance become evident and it becomes clear how they attempt to influence the public transcript and how Foucault’s technologies of self are integrated with technologies of domination.

I read the purposefully chosen transcripts, understanding that they are technological productions of the talk at the actual hearings. Because I did not “hear” any of these presentations, I am missing the gestures, postures, movements, tones, and silences that come with talk. But the text itself provides enough of the “who-ness” of the presenters and the committee members to fill in spaces left by not being there in person. Because I spent about two hours attending one hearing, I can also imagine a similar room set up in which each presenter spoke as well as the physical location of the presenters and the committee within these rooms where the hearings were held throughout the province. The formal structure of the hearings and the physical setting are the places where domination and resistance happen and contribute to my understandings of both. I also bring my own experience to my reading, which includes an understanding of the wider contemporary social and political context and a growing appreciation of the discourses that influence my thinking and inform my analysis and awareness of how discourse works.

**Strategies of Resistance in Oral Presentations**

The people who came to these hearings, who took the time to create a written submission and formulate it into an oral presentation, and who gathered the courage to present in this formal setting may see this kind of participation as a right of citizenship. They are also responsible in that they responded to the “duty to participate”. They have been given “a chance to participate” in what they likely understand is a democratic process and they rose to the occasion. They are engaging in citizenship.

Recalling that Aptheker takes exception to the oppositionalisation of much theorisation of resistance and power and suggests that there is a whole world of resistance

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6 Peterson and Lupton 146.
that is outside of any social or political theory or any traditional assumptions, I am compelled to consider her perspective. She argues that resistance is not necessarily oppositional. Thus, before I even read the transcripts, I take the very acts of coming to these rather formal public hearings to present a perspective counter to the committee’s, in and of themselves, to be acts of resistance by these presenters. Yet, at the same time, they are participating, they are active participants in the creation of discourse. Their purposes may well be to affect the debate, to participate in meaning-making, to give a message to this committee, and to influence policy development through the recommendations the committee will make to the government.

Beyond the presence of these presenters, however, is a sense of opposition. I have chosen these particular presenters because of their substantive expression of opposition to the increase in privatisation and profit-making of health care. Entering into a process where power relations are palpable, resistance is inevitable. Registering their opposition became their purpose. That they are engaging at all signals resistance; their presentations of opposition are acts of discursive resistance.

I read the transcripts of these presenters sharing their sense of opposition. I agree with their overarching tenet that privatisation and profit-making in health care are fundamentally problematic. Furthermore, they are contradictory to my values. While I bring this bias to my research, my interest moves from the pros and cons of privatisation and profit-making (a critical review of these discussions motivates and informs my thinking) to what this opposition looks like and how it is taken up. My curiosity about what is happening within and to the opposition has led me to read these presentations with particular interest in how the presenters manifest their opposition, how they engage in resistance, and how their resistance is shaped. By exploring their strategies, the purpose and effects of these strategies, and the response to them, I gain insight into resistance, especially in relation to powerful, embedded forces. I also see discursive power relations at work.

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7 Strong Medicine for Health Care
8 Aptheker 173.
In reading the 22 transcripts of the oral presentations, I look for the who, what, how, and why of the presentations to reveal what I am calling strategies of resistance. Cognisant that not everyone who wanted to present was granted a time slot at a hearing and of the limited time allotted to those who did make the list, the presenters want to take advantage of the “opportunity” to give a clear message to the committee. They have very carefully and thoughtfully planned their presentation. How do presenters engage with resistance? What strategies do they employ? What purposes do these strategies seek to accomplish? How do these strategies affect the debate? Is there a relationship between how the debate is shaped and framed and these strategies?

Each presenter uses a number of strategies and not all presenters utilise all the strategies. These strategies take many forms, some are used by multiple presenters, some are unique to just one presenter. The strategies overlap and are intertwined, yet some differ vastly from others. I have grouped the strategies roughly into five categories and within each are a variety of techniques. These categories are not mutually exclusive in that the strategies are not employed in isolation from one other. Each attempts to affect the debate in particular and unique ways. The strategies are presented in the following table. They are listed in an order that made sense from an analytical perspective. In part, they are ordered as they typically appeared in the presentations. The last strategy attempts to be different from the others in that it looks beyond and forward.

Table 7: Strategies of Opposition to Privatisation and Profit-Making in Health Care

- Claiming Authority
- Setting the Tone and Establishing a Relationship
- Debating the Limits of the Dominant Discourse
- Exposing the Manufacturing of the Dominant Framing and Re-Politicising the Debate
- Attempting to Start with a Different Premise

Claiming Authority

The first group of strategies seeks to claim authority and demands to be taken seriously. It is about placing oneself in relation to this formal public hearing process. Presenters stake a claim and name the place from where they speak, experience, and feel the passion they put into their words; it is through their words that I get a sense of their who-ness and how it matters. Through the use of various techniques, presenters give the
committee cause to take them seriously and demand they do so. They back up their arguments with evidence in the hope of being convincing and contributing to the public transcript and “truths” to be considered. They also bolster their position by asserting their role as “experts”. Because most presenters are not paid to attend the hearings nor hold positions that would traditionally be considered authoritative on health care, they are challenging the foundations of what constitutes expertise.

Along with demonstrating themselves as responsible, assuming responsibility as patients and caregivers, they have also assumed responsibility for active participation in this consultative process and assert their right to be taken seriously. Presenters speak to their rights of political citizenship; their authority derives from their status as citizens. Furthermore, they demand that they be granted the rights associated with their understanding of social citizenship. Table 8 presents the specific techniques within and purposes of this strategy and is followed by a description of the most salient techniques.

Table 8: Claiming Authority

<table>
<thead>
<tr>
<th>Techniques:</th>
<th>Purposes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positioning/Not positioning</td>
<td>demand to be taken seriously and that their knowledges and expertise be counted</td>
</tr>
<tr>
<td>• Drawing on knowledge bases</td>
<td>stake a claim and name the place from where they speak, experience and feel the passion they put into their words</td>
</tr>
<tr>
<td>• Providing evidence</td>
<td>back up arguments with “evidence”; state their position as “experts”</td>
</tr>
<tr>
<td>• Story telling</td>
<td>self-legitimate and claim epistemology</td>
</tr>
<tr>
<td>• Sharing anecdotes</td>
<td>challenge the idea that a presenter needs to justify his knowledge/epistemology</td>
</tr>
<tr>
<td>• Challenging the illusion of citizen engagement</td>
<td>demonstrate how citizens assume responsibility for active participation in the policy-making process</td>
</tr>
<tr>
<td>• Tendering written submissions</td>
<td>reveal scepticism of “participation”</td>
</tr>
<tr>
<td>• Selecting focus of presentation</td>
<td></td>
</tr>
</tbody>
</table>
Positioning

The most prevalent technique used by almost all the presenters is what I am calling positioning. This technique almost seems to be one of common sense: identifying oneself or the role one plays as an introduction to, or throughout, a presentation. This technique does more than merely identify the speaker and introduce a presentation and is more than just good manners. It provides a base and lays the groundwork for asserting the authority to make claims or assertions and expecting credibility. A presenter can say what she says because of what she knows and she knows what she knows because of her place in and experience with the world. “I’m the mother of two daughters [...]. I’ve worked as a long term care aide for 25 years [...]. I’m a cancer survivor and I’ve suffered with chronic lung disease since childhood.” This presenter lists the places she speaks from, the experiences she has had that gives her credibility and expertise. Without this positioning, a listener may wonder how a presenter can say what she says, how she knows what she claims to know. She is self-legitimising and claiming her epistemology.

According to Goffman⁹, positioning allows people to make themselves comprehensible to others. It makes evident the discourses from which people draw or with which they engage; it is a discursive production of self or selves. In speaking and acting from a particular position, people are bringing to a situation their history as subjective beings, the history of those who have been in multiple positions and engaged in different forms of discourse. One presenter says:

My union [...] represents 65,000 workers, just under half work directly in the provincial public service, another 33,000 workers work in the provincial public service which includes the community social services, community health and advanced education sectors and as well as the private sector, of those 13,000 are health care workers.

The key value in the positioning of this presenter is the numbers of citizens who are being represented by this presentation, people who have a strong history working in the health care system. The intent or hope is that the committee will consider the thousands who

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are members of the union this presenter represents. This presentation is more than just one person’s voice.

Diametrically opposed to, or perhaps more a sub-category of, positioning is the counter technique of not positioning but beginning a presentation by going straight to the point, skirting any attempt to engage or entice the committee to listen. While positioning is more than just good manners, not positioning ignores social mores. It challenges the idea that a presenter needs to justify his epistemology of how he comes to know what he knows. A couple of presenters do not reveal their particular experience or explain how it is that they have solid knowledge and can legitimately further an argument. This approach is really a positioning of its own. Those who employ this technique appear to have a particular understanding of what is expected of good citizens: be polite and justify your place at this hearing. The formality of these hearings almost demands a particular way of participation, an appropriate or approved model of action. Presenters utilising this technique understand the possibilities of citizenship differently, however. They challenge the norm or the prescribed, mannerly affect and instead jump straight into making their point with conviction and passion, making clear the discourses within which they operate. Knowing that their time is limited with the committee, they waste no time getting to their point.

**Drawing on Knowledge Base**

An extension of positioning is the act of drawing on one’s knowledge base. Many presenters draw on their knowledge bases to make their arguments. Because of presenters’ experiences and knowledge, they have certain expectations and can make certain claims. This technique shows the committee that presenters have valid knowledge against which they will measure any recommendations the committee makes. In many decision-making processes, “experts” are called upon to give advice. In health care, it is often physicians, economists, policy makers, and health administrators who are deemed the experts. In these presentations, presenters challenge this limited understanding of expertise and assert their own expertise as equally valid. Positioning themselves as patient, caregiver, health care worker, and/or citizen, presenters put themselves forward
as people who understand the system, who have experienced its positive and down sides, and who can make a valuable contribution toward determining what their health care system can, and indeed should, look like. They are demanding that their knowledges be counted as expertise.

One woman claims her authority from several positions. Her knowledge of being both a family and employee caregiver is important to her and others, providing experiential expertise. It is, however, not likely what the committee would consider expertise. She adds that she was appointed to a community health council for several years, a position that may gain her some status. She says:

I've worked in the field [community health worker] for almost 13 years as well as being appointed to the community health council in [S], so I do have a pretty good understanding. [...] Previous to that I was involved with providing health and mental health care to three family members from a very young age. [...] I was about 12 years old when we as a family were challenged with the emotional and physical complexities of living with persons with physical disabilities. [...] We were tasked with bathing, cooking, laundry, bowel routines, changing of bandages, transfers, assisting with medication, and the list carries on.

Another presenter in attendance with a colleague comes the closest to being what might traditionally be considered an “expert”. “I’m acting chair of the [P] health council; I have with me our CEO; [...] I’m a businessman myself; a B.C. taxpayer; [...] a parent.” He has been appointed to administer a health council and is a businessman who understands the role of profit in businesses. His colleague was hired in a position high on the hierarchy of health care administration. That the presenter is also a tax payer and a parent broadens his interests.

Providing Evidence

As proof of their knowledge, many presenters provide the committee with evidence. Evidence-based decision-making is widespread in many practice disciplines and in some academic circles.\textsuperscript{11} It constitutes a discourse in and of itself. Evidence is

\textsuperscript{10} Burchell “Liberal Government and the Techniques of Self,” 266.

\textsuperscript{11} Mark Avis, University of Nottingham and Dawn Freshwater, University of Bournemouth “Evidence for Practice, Epistemology and Critical Reflection” Presentation notes for In Sickness and In Health: Shaping Health Care: Power and Agency, Reykjavik, Iceland June, 2004.
cited by those who are justifying decisions, the implication being that decisions which are evidence-based are proven to be the best decisions, thus not to be debated. The concept of evidence-based decisions is closely, although not strictly, associated with neo-liberalism, which relies on “experts” who base their judgements on scientific objective knowledge. Accordingly, those who are “non-experts”, such as lay people, rely only on common sense and subjective knowledge\(^\text{12}\), deemed less valuable ways of knowing. Presenters refuse to accept that only certain experts have evidence and that only certain kinds of evidence are legitimate. They bring their own version of evidence to these hearings, some of it based in science and most of it challenging the dominant framing. By doing so, they hope the committee will recognise their expertise and take their presentation seriously. Their presentation of evidence that contradicts the dominant framing attempts to shift the committee’s commitment to a particular discourse. It also challenges the very notion of evidence-based as un-problematic.

Presenters provide traditionally accepted objective evidence in the form of statistics, numbers, and percentages to the committee that, in many cases, challenge those that have been used to justify the notion of “crisis”. Quantitative data are taken from sources and research institutes likely seen as credible by the committee such as the Canadian Economic Observer, New England Journal of Medicine, the Canadian Institute of Health Information, and the Canadian Health Association. The evidence from these sources demonstrates a magnitude that is different or is interpreted differently than when cited as evidence in the dominant framing. However, much of the evidence the presenters provide is grounded in experiential- and practice-based knowledge and results from a critical reflection of this experience\(^\text{13}\). People have a right to their experience and given that policies affect people’s lives, presenters want the committee to hear the stories that describe those effects. They insist that this kind of evidence is as valid as the statistical and quantitative evidence on which the state relies almost exclusively. For example, one woman who is the spokesperson for a community coalition offers this piece of evidence:

12 Peterson and Lupton 153.

"We have example after example of seniors who are losing their independence by being placed on extended care lists, but who, with home support, could maintain their dignity at home." Like others, she is trying to convince the committee that citizens are being very responsible and independent yet face barriers that result from cutting costs.

Written submissions provide a tangible reminder of presentations, hindering any chance the committee may forget their points. Many presenters attach documents that serve as evidence to their claims such as information from the Canadian Institute for Health Information (CIHI). Written submissions may also add credibility to a presentation and may be seen by a wider audience than the committee.

**Telling Stories and Sharing Anecdotes**

Much of the evidence is mediated through narratives, testimonials, and anecdotes, which collectively I am referring to as stories. Personal stories of individuals make sense of the discourses presenters draw from and add credibility to their arguments. They capture the voices of the individual and the many. According to Lyotard, the "sense-making strategies" of personal narratives "resort to and corroborate, but also resist and subvert, socioculturally dominant master narratives"14. They are personal accounts depicting how people account for and make sense of their experiences, accounts of how something works or does not work. They make room for inference and attempt to influence and appeal to the committee members' hearts as much as to their heads. These stories are chosen for a particular reason—to counter, challenge, and give new meaning to concepts and language. Fischer suggests that often, whether or not consciously, narrators hope to encourage others to arrive at a particular conclusion themselves, and thus stories are a communication strategy.15 The stories of the presenters demonstrate how they come to make the claims they do.

Table 9 contains an example of a story with a context, characters, conflict, and attempts to resolve the conflict. The conflict is about enormous personal work and responsibility required to care for a sick family member, labour that intensifies with

limited or no support. This compelling and emotional offering of a glimpse into the presenter's life injects into the debate a human face that counters the dominant framing that suggests people need to be more responsible. It also puts a human face on the impacts of policy decisions. Inserting the human into policies is something many presenters do in an attempt to convince the committee that policies are more than just words written on papers and impact more than just the financial bottom line. This story is taken from a transcript in *Hansard*. Although the transcripts are in the public domain, I have removed any details that may identify the speaker in keeping with my commitment to the University of Victoria Ethics Committee on Research and Other Activities Involving Human Subjects.

*Table 9: Example of a Story from one Presenter*

| My brother, who was much older and extremely independent and strong by nature, was confronted with being confined to a wheelchair for the rest of his life. His choice of lifestyles as well as dreams changed forever. We were tasked with bathing, cooking, laundry, bowel routines, changing of bandages, transfers, assisting with medication, and the list carries on. It was not uncommon for me to be called home early to care for them while my mother took a breather or ran errands. Even after moving into their home, I was still tasked with the care of my sister-in-law in the evening hours and on weekends because home support was not available to them whenever my brother was hospitalized. I want you to understand that I was robbed of my youth. From the time of my brother's life changing illness, I lost both my mother and my father. My father worked harder because that was all he knew. It was the only way he could deal with his own emotions. My mother's attention was directed solely to my brother and sister-in-law. My parents didn't have time for me. I was afraid to talk to my parents. I didn't want to place any more burden on them. I felt totally isolated. I can't express the emotions that I went through and dealt with on my own.

Where was our support? My personal testimony clearly expresses the dire need and the pressures that the families have to contend with. The community health programs that we have today alleviate some of those pressures and provide the support so desperately needed. To take them away or cut them is a crime.

**Challenging the Illusion of Citizen Engagement**

Many presenters speaking to the committee are conscious of their obligations and responsibilities as citizens and demonstrate at these hearings, through their presence and their words, how they take this responsibility very seriously. They speak to their rights of

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15 Fischer
political citizenship. But they are also sceptical that these rights will be honoured and are acutely aware of the critiques of this process called consultation. Suspicious of the illusion of participation, many call on the committee to take seriously their alleged commitment to public consultation. By doing so, they reveal their scepticism, call into question the integrity of the process, and allege that committees like this one often, or maybe usually, have pre-ordained agendas. Several comments are reminiscent of what Aronson found in her analysis of a 1991 Ontario provincial government report on long-term care, observing what appears to be preset limits to the consultation process and fixed agendas within predetermined bounds.\textsuperscript{16} Says one businessman arguing against health care as a place for profit-making:

\begin{quote}
I'd like to challenge the administration to respond to these proposals rather than the usual response of standing committees to thank witnesses for their contribution and ignore the input that does not coincide with their preordained agenda. And I apologize—this committee seems to be a little more receptive, on the surface anyway, than the previous committee that I spoke to.
\end{quote}

Remembering the prescribed manners required of this formal process, most of the presenters who speak to citizen engagement do so respectfully and request that the committee rise above the expected ways of conduct. But they are making known their misgivings. Many speak passionately against actions such as increasing user fees, allowing more private clinics, reducing services covered by the Medicals Service Plan, examples of how they view privatisation and profit-making. They also suspect that the committee has already established its recommendations and that these actions are ones the government have already planned to implement. Perhaps they also hope that by voicing their misgivings, the committee will feel compelled to prove them wrong.

**Setting the Tone and Establishing a Relationship**

The second grouping of strategies sets a tone, attempts to develop a relationship with the committee, and sets the terms of that relationship. They affect or achieve a particular way of hearing. The use of these strategies often reveals the nature of a particular presenter who may choose a style that comes naturally to her, one in which she

\textsuperscript{16} Aronson, "Giving Consumers a Say in Policy Development" 372.
is trained, one she believes will be effective, or one that she thinks will be heard and taken seriously. The following table outlines this grouping.

*Table 10: Setting the Tone and Establishing a Relationship*

<table>
<thead>
<tr>
<th>Techniques:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Politeness</td>
<td></td>
</tr>
<tr>
<td>• Giving benefit of doubt, sharing blame, softening</td>
<td></td>
</tr>
<tr>
<td>• Rhetorical questions</td>
<td></td>
</tr>
<tr>
<td>• Non-rhetorical questions</td>
<td></td>
</tr>
<tr>
<td>• Sarcasm/cynicism/cheekiness/mocking</td>
<td></td>
</tr>
<tr>
<td>• Shaming</td>
<td></td>
</tr>
<tr>
<td>• Familiarity</td>
<td></td>
</tr>
<tr>
<td>• Speaking directly to committee member</td>
<td></td>
</tr>
<tr>
<td>• Warnings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purposes:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• attempt to develop a relationship with the committee and set the terms of that relationship</td>
<td></td>
</tr>
<tr>
<td>• affect the way the committee will hear a presentation</td>
<td></td>
</tr>
<tr>
<td>• respect the process, disrupt the discourse</td>
<td></td>
</tr>
<tr>
<td>• reduce distance between committee members and presenters</td>
<td></td>
</tr>
<tr>
<td>• express rage in acceptable way for this social site</td>
<td></td>
</tr>
<tr>
<td>• discredit the dominant discourse</td>
<td></td>
</tr>
</tbody>
</table>

*Politeness and Sharing the Blame*

All the presenters are respectful, polite, and thoughtful. Many offer accolades such as expressions of praise and gratitude to the committee for providing the opportunity to speak and for their time. For example, one presenter positions herself as a nurse with a background in intensive care, a teacher of undergraduate and graduate students, and a researcher at a university. She says:

I'd like to start by thanking the Legislative Assembly of British Columbia and the Select Standing Committee on Health for the opportunity to participate in this public hearing. [...] I think the first thing I want to say is that the Liberal government has made a promise to be accountable to the people of British Columbia. I really want to emphasize that an opportunity such as this, for a public dialogue, is a tremendously important means of keeping that promise. I'd like to thank the committee.
A couple of presenters temper the responsibility of the BC Liberals for the current and predicted situation within health care; they are willing to see that the responsibility should be shared with other jurisdictions such as the federal government and the previous provincial NDP government. Acknowledgement that “I realize there are no easy answers for any of us, but I ask that you consider the cautions I have outlined” comes across as rather understated given the passion of the argument made earlier in this person’s presentation. The presenter who speaks on behalf of a community coalition is willing to divide up the blame and the responsibility: “You will agree, I know, with our next recommendation that you strongly lobby the federal government to return to paying a much higher share of health costs. Until that happens, you have our support in retracting the provincial tax cuts.” But in doing so, she also admonishes the provincial government for bringing in tax cuts, which they did immediately after being elected.

A presenter whose first comment to the committee is tentative goes on to argue passionately against the further reduction of community health support programs:

(h)opefully, you’ll be patient with me because my writing is a little better than my speaking. [...] The reality is frightening. Cuts like these over a three-year span will cut deeply into health care programs. Or you can put a Liberal spin on it and justify it with further privatization. I’m sorry. I do not mean to slam the Liberal government. It’s their policies.

She does not want appear to “slam” the powerful people who sit in front of her, so remains courteous to keep the committee’s attention. She is far more articulate than she originally gives herself credit for and has a reasonable analysis of how the government will work to justify privatisation.

While certainly not equivalent to the slaves in Scott’s treatise on resistance, the presenters to these hearings appear to be aware of their subordinate position in relation to the committee. They are interested in disruption, but the disruption of ideas not the disruption of these hearings or the process. No one engages in acts of rebellious defiance. This public place expects—almost requires—a very conscious awareness of power relations. The committee has depicted itself as being interested in hearing what citizens have to say about the future of health care in B.C. as they formulate recommendations to the government. Given their request for citizen input, they have granted what Scott calls
"rhetorical space"\textsuperscript{17} in which citizens can make their case. The participants' contribution to this consultation process is not likely seen as bold acts of resistance by the committee. But it is resistance.

The politeness of all the presenters could be perceived as deference. Scott argues that this impression of compliance may be much more than it appears. Similarly, this politeness is a behaviour stemming from what Foucault calls the practice of the making of the self. It is the effect of dominance and discipline. Through the shaping, regulating, and disciplining of practice, behaviour is shaped. Given the formality of the hearing process and the expectation of compliance, to do anything but comply with the rules of public conduct would be risky; the rhetorical space would firmly close. Participation in this performance requires a level of deference; any act of defiance is restricted by the disciplining nature of the hearing process, Foucault’s technique of power. Using Foucault’s governmentality approach, such politeness and accommodation can be understood as self-control in relation to political rule. What appear to be the committee’s constraints on or coercion of the presenters also becomes practised as self-modification by the presenters. They are participating in their own discipline, in part so they will not be easily dismissed as impolite or inappropriate. But they are also engaged in their own acts of disciplining of the committee and the public; by offering words of praise and being gracious to the committee, they are setting up the committee to be open to their arguments. Aptheker’s analysis also fits: “what appears as collaboration or accommodation [. . .] may be reinterpreted [. . .] as resistance”.\textsuperscript{18}

\textit{Sarcasm, Cynicism, Cheekiness, and Mockery}

A technique that stands out in several presentations but plays a major role in two is the use of shaming, cheekiness, sarcasm, mockery, and cynicism, all of which set a very different tone than that set by politeness and respectfulness. Scott argues that dignity and autonomy—his particular interests—are typically seen as secondary to material

\textsuperscript{17} Scott 18.
\textsuperscript{18} Aptheker 180.
exploitation as issues of domination. He contends that recipients of acts and rituals of denigration, insults, and bodily assaults are usually subordinates who are denied the opportunity for reciprocity, such as a slap for a slap, an insult for an insult, by and within the power relations. In these hearings, it would be entirely inappropriate for a committee member to consider such overt and literal acts of domination. However, in a reversal of Scott’s analysis, it is a couple of presenters to these hearings, subordinates, who engage in what comes arguably close to insulting. One presenter relies heavily on this technique. The analysis by this community activist on the workings of the dominant discourse is detailed and revealing and is done largely through his use of sarcasm and cynicism. His tongue is firmly planted in his cheek as he makes underhanded allegations:

There is one huge problem with our health care system. The problem is that it does not provide enough profit to the corporations who rule this country. Of course, privatization has nothing to do with cost. The people behind this do not care about which way is cheaper. The important thing is to privatize, because there’s money to be made, and people have decided that it’s time to privatize. In a corporate democracy the role of the corporate government is to do just that.

Another presenter who is leader of a union uses a similar technique. He lists eight quotes of commitments made by various members of the BC Liberals leading up to the election. For example,

Privatization. ‘I don’t think there’s any appetite in British Columbia to do any kind of privatizing of health care. Indeed, I don’t believe we need to do that. We have a long way to go in British Columbia before we maximize or optimize the benefits to the public health care system, and we are committed to helping the public health care system work.’ March 2000.

Following these quotes, the presenter says “I agree with those Liberal statements”. Because he is a subordinate in this relationship with the committee, the committee members, who are the dominant elite, are in a position to reciprocate. The cheekiness and sarcasm is picked up by the committee chair and thrown back at him, like sparring. She replies, “We’re delighted to hear that” to which the presenter replies “I’m glad”: a cheek-to-cheek dialogue.

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19 Scott 22-23.
Scott suggests these acts are usually reserved for the hidden transcript\textsuperscript{21}. Likely the presenters who are careful and polite in the public hearings are, behind the scenes, as sarcastic as the community activist is publicly. But this presenter brings this practice out from backstage. The perceived failure to abide by the rules requiring politeness is taken by the committee as an act of insubordination. The consequence is a final dismissal from the committee and disregard for the presentation, its content, and its presenter. He argues against privatisation and profit-making in health care and exposes how these concepts are constructed as logical solutions to the constructed problem ‘crisis’. That his style of cheekiness and sarcasm comes across poorly is something perhaps this presenter knows all too well but has chosen to ignore. Being polite does not provide other presenters with any more response than he receives and he is able to make his point to other people beyond the committee, to those in attendance at the hearings and those reading the transcript of his presentation. Likely sceptical of the sincerity of this consultation process anyway, he is thumbing his nose at the process and the public transcript.

\textit{Rhetorical Questions}

A gentler, more benign variation of this cynicism is the asking of rhetorical questions. “What makes one person’s life more valuable than another’s?” “If a person is dying in four weeks, must the province really charge a user fee for home support?” Rhetorical questions are not asked with the expectation of an answer; there is an implication that the answer is obvious. They are used to persuade someone of a line of reasoning without argument or to emphasise a point by stating its opposite ironically.\textsuperscript{22} Used in these hearings, rhetorical questions discredit those who might disagree with the “obvious”. Yet the obvious is already happening. This technique overlaps with shaming, an exposé and publication of practices, corrupt in the eyes of the presenter.

\textsuperscript{20} One could argue that there are plenty of slaps and insults by the committee or the government but they are so covert they could be denied.

\textsuperscript{21} Scott 23.

Familiarity

A couple of presenters speak directly to committee members using their first names. With this familiarity, presenters are attempting to remove the distance between themselves and the committee members, reduce the committee’s power over the presenters, and create a level playing field. When a presenter representing a union repeatedly uses the chair’s first name and speaks directly to her, he reinforces this familiarity. This presenter and other members of his presenting coalition put forward a carefully thought-out, respectful presentation. Yet this use of familiarity exposes what Scott calls “attitude”\(^\text{23}\) that may be hidden in other presentations. In response, the chair hands “attitude” right back by calling him “sir”.\(^\text{24}\) She reminds him, in a rather sarcastic way, of their respective roles and what kind of behaviour is acceptable. She is reinforcing the power relation and reminding him of his subordinate position.

Warnings

The issuing of warnings in such a formal public setting comes the closest to expressing rage. In the context of these hearings, presenters must, and do, perform within understood confines and in an acceptable manner. Anger must be controlled; “making a scene” and letting out anger would not likely be considered socially acceptable, may not be practical in this formal public setting, and may generate some kind of retaliation. It is generally reserved for the hidden transcript. Likely burning with rage, a few presenters issue warnings as a way of expressing this rage without doing so outwardly and risk being completely negated or asked to leave. “The most radical thing a worker can have is a long memory. I think that’s very important to remember.” This union leader’s statement sets the context for a list of quotes found in government speeches or documents, most made just prior to the last election, commitments he says people remember. He does not call the committee or the government liars; he makes no explicit allegations. He balances

\(^{23}\) Scott 24.

\(^{24}\) She later calls him by his first name but by then her point has already been made.
controlling his feelings with getting his message across. It is not unlike "the effort by subordinate groups to call down a curse on the heads of their aggressors".25

**Debating the Limits of the Dominant Discourse**

This group of strategies, outlined in Table 11, is utilised frequently and subtly yet powerfully. It is in this group that the effects of discourse and its constituent concepts and language are evident: how they are understood, how they frame, shape, and affect the debate, and how they are contested.

*Table 11: Debating the Limits of the Dominant Discourse*

<table>
<thead>
<tr>
<th>Techniques</th>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Speaking to language and concepts of dominant discourse: efficiency, accountability, personal responsibility, partnering with private sector, relieving fiscal pressures, profit-making, effectiveness, consumer, choice, fiscal responsibility, fear</td>
<td>• respond to the production of the dominant discourse and attempt to incite the production of a counter discourse</td>
</tr>
<tr>
<td>• Exposing contradictions</td>
<td>• capture the committee's interest and draw them in</td>
</tr>
<tr>
<td></td>
<td>• employ the language and concepts that the committee will understand, hoping they will be listened to and their arguments taken up</td>
</tr>
<tr>
<td></td>
<td>• disrupt the dominant discourse, to dislodge the adherence to it, and to open up space for meaningful dialogue and re-conceptualisation</td>
</tr>
<tr>
<td></td>
<td>• attempt to define and clarify</td>
</tr>
<tr>
<td></td>
<td>• demonstrate the inconsistencies within the dominant discourse and how the rhetoric is incongruent with people's lived experiences</td>
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<tr>
<td></td>
<td>• reveal the discrepancies within and between dominating ideas and concepts</td>
</tr>
<tr>
<td></td>
<td>• demonstrate personal responsibility and barriers constructed by policy</td>
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</table>

The language and concepts of the dominant discourse are unmistakable in the dominant framing of the debates around health care specifically and their effect is apparent in the overall policy agenda of the BC Liberal government. The same concepts and language are also evident in the presenters' strategies of resistance as they are taken up and form part of the oppositional discourse. So dominant are they that they have

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25 Scott 42.
permeated the counter framing of the debate. That the dominant discourse is countered so vehemently and passionately attests to its powerful and commanding effect. Presenters are responding to the production of it and attempting to incite the production of a counter discourse while using its constituent concepts and language.

*Speaking to the Language and Concepts of the Dominant Discourse*

The dominant discourse is one that this committee understands, perpetuates, and produces. By speaking to it, presenters are employing the language and concepts that the committee will understand with the hope that they will perhaps capture the committee’s interest, draw them in so they will be listened to and their arguments taken up. In a way, they are demonstrating shared values, as if to say we, too, understand the need for efficiency and responsibility, for example. They are embracing the rhetorical space created for their input and attempting to expand that kind of space to challenge the committee’s assumptions. If presenters speak to these concepts and get taken seriously, perhaps they can effect a re-conceptualisation; if committee members can be convinced that citizens understand the importance of these concepts, they may be open to a re-framing of these same concepts, or so these presenters hope. Language is not static. Dominant meanings can be contested and turned around, alternative meanings affirmed. Through re-conceptualising, presenters are providing different meanings for the concepts the committee understands and that play such a strong role in the discourses of the dominant framing. Collectively, various strategies serve to demonstrate the effects of these concepts, how their manifestation impacts people’s health and lives, the inconsistencies within the dominant discourse, and how the rhetoric is incongruent with people’s lived experiences.

The concepts which are addressed by the presenters include: efficiency, accountability, personal responsibility, partnering with private sector, relieving fiscal pressures, profit-making, effectiveness, consumer, choice, fiscal responsibility, and fear. The presenters do not necessarily name these concepts as such but speak to them nonetheless in stories, suggestions, questions, and arguments and often contest them and present alternatives. These concepts are inherent in the dominant framing which is also laden with vague maxims and promises: save our health care, putting health back into
health care, patients first, protect and renew public health care, solve the crisis, put people’s needs at the centre of health care again, commitment to the Canada Health Act, controlling costs, need to deal with funding pressures, and sustainability. Neither the government nor the committee is explicit in what they mean by some of these concepts and promises. There is an assumption of common sense: surely everyone will understand “put health back into health care”, for example. Yet within this assumption, there is an intentional lack of definition or clarity that gives the committee space to use whatever meaning they like, whenever they like, capitalising on the ambiguity. Presenters are attempting to narrow the definition (just as the committee narrows the dominant framing), clarify, or challenge what they believe is the assumed definition.

An individual presenter who identifies himself as a business man who understands the need for profit offers: “What we need is an aggressive program of education and preventative medicine to ultimately reduce downstream costs of the health care system. Due to fiscal pressures on the system, it’s clear that the status quo is not a sustainable option.” His entire presentation is a combination of agreeing with some of the goals of the committee and arguing that privatisation and profit-making is problematic, thus, not the answer. A presenter speaking as an acting chair of a health council says: “We do, however, recognize that we may have to reconsider and redefine what we as a province can afford, but user fees are also not the answer to controlled budgets and utilization of services.” Both these presenters speak to the dominant framing but add their own clarification.

Exposing Contradictions

Presenters demonstrate that often policies meant to support assumed outcomes defined by particular concepts actually do the exact opposite. In attempting to define and clarify, they speak to what these concepts mean to them and how they experience them. Rather than attempting to draw the committee in, presenters expose the contradictions within the dominant discourse. They argue that those assumptions are not universal, not applicable to every circumstance, and, in some situations, erroneous. The assumed goals are often not met and people’s health and health care often deteriorate—a direct contradiction to the assumed goal. This exposé of contradictions points to vagueness
within the dominant discourse and the inconsistencies between the rhetoric and the reality experienced by real people living real lives.

Contradictions reveal the conflicts within and between dominant ideas and concepts. They introduce uncertainty. With this uncertainty comes doubt and with doubt, space is created for differing understandings, re-conceptualisation, the possibility to look at things differently. These contradictions are expressed in stories, the presentation of alternative analysis, and contrary evidence. Presenters hope that by pointing out the contradictions, the committee will see that their assumptions are not givens and in some cases problematic and open to re-conceptualisations.

The woman speaking on behalf of a community coalition argues that the introduction of user fees translates into a two-tiered system and, as such, it contravenes the principles of in the Canada Health Act to which this government has pledged allegiance. User fees also contradict Campbell’s commitment in the New Era document: “Establish provincial health standards that ensure all citizens in every part of the province are entitled to equitable, reliable, high quality health services”. If user fees become a barrier to some citizens accessing some health care, then all citizens are not ensured their entitlement.

In another example, the community activist points to a blatant (“of course there is”) contradiction in the debate increasingly narrowed to be one of costs: “there’s so much money that you guys just gave a huge tax break to your friends in the upper-income and corporate communities, and the Chrétien government just gave the largest tax break in Canadian history [. . .] 60% of it going to the highest-income 10 or 15%, who need it the most”. He is pointing to what another presenter articulates outright: “There is no doubt why women and British Columbians become disillusioned with politicians. It’s because they hear something, but then, at the end of the day, something quite contrary is delivered.”

The technique of exposing contradictions and the details revealed in the exposé betray something about how the dominant discourse works to neutralise events or situations. However, often these situations are experienced as contradictory and, therefore, problematic by the presenters. People tell stories that demonstrate how responsible they are yet their families still suffer, their health suffers, their ability to
continue to care for others suffers. For example, one woman with experience of her own health challenges and of working as a health care professional points to the creation of situations which put people's health at risk, situations that contradict the committee's commitment to put "patients first". She challenges the government's proposed cuts to Pharmacare on economical grounds—"penny wise, pound foolish"—a contradiction to the government's and this committee's goal of saving money and increasing accessibility of health care to those who need it.

Another presenter who works for a for-profit care facility provides examples of contradictions to the commitment of patients first. As she eloquently describes, in her experience in a profit-making facility, patients and care come long after profit is made.

I do not have a problem with people making money. Everybody understands that shareholders are the reason we have profit, but I do not even know if shareholders would be happy to see, for example, that I am the only full-time recreation aide in a large facility. There's no possible way I can give my undivided attention and proper care to residents living there when there's only one full-time person. I do not know if you're familiar with the recreation activities that we do with our seniors. My time is very precious in my job. I do not have a lot of time for a senior who's crying or having a bad day or sad or lonely, because we do not have that time. In private for-profit, we never have enough supplies to work with. Every day our care aides come on the floor—and these seniors are the ones that fought for our country, gave us our Medicare—and they do not have proper supplies to work with. We do not have proper lifts to do the patients. Sometimes there is nothing to put on these patients, and the staff are using towels.

This presenter cites the contradictions that face workers daily. She is clear that staff want to do their job, to be responsible, but that such responsibility is difficult without the resources to do their job well. Additionally, individuals are told repeatedly that they have to be responsible, but the corporations who are contracted to provide care apparently are not held up to the same standards. Care is actively removed so that profit can be made.

A representative from the B.C. Nurses Union shows nurses' sense of responsibility to participate in this process and their commitment to professional responsibility:

We felt we had an obligation to come here this afternoon and give the unique perspective of registered nurses on this issue. [...] Our experience as registered nurses comes from our long fight to provide quality hands-on care to patients during many years of management and government
restructuring schemes. All too often the choice given us has been between controlling costs and providing quality care to our patients. When nurses are faced with a choice between cutting costs or providing quality care to patients, nurses will choose quality patient care every time.

Their professional responsibility is compromised by cost-cutting measures. She exposes the contradiction in the choice nurses have been forced to make: be responsible to management or to their patients.

The clichés “bring the health back into health care”\(^{26}\) and “put patient care first”\(^{27}\) are two promises of this government. Yet the changes brought about to create efficiencies result in reducing health and putting profit before the patient. According to many presenters, when you save one way, you pay in another, and that cost is usually a human cost. Poor care results in the need for increased care.

The presenter speaking on behalf of a community coalition provides examples of policies that have sanctioned, or in fact mandated, the removal of services that afforded the opportunity for people to live independently or semi-independently in the community. When the system removes the supports that afforded people some independence or semi-independence, it is actively turning them into or constructing them as patients in need of acute or extended care. Turning healthy people into patients is a consequence of the government’s attempts to reduce costs in the short term. People requiring assistance end up in isolation at home or as patients in institutions. They are removed from the community where family, friends, and community members can reasonably care for them as individuals, not patients. Presenters argue that the deterioration of people’s health, isolation, “burned out” friends and family, and the requirement of acute or extended care are the logical yet illogical—akin to iatrogenic—consequences of short-sighted decisions. Health turns to illness. This technique demonstrates the consequences of some policies, diametrically opposed to the alleged intent: the illogic of logic.

Seeing the dominant framing as limiting and narrowing the debate, these presenters demonstrate the inconsistencies within it. By doing so, they are trying to disrupt the dominant discourse, to dislodge the adherence to it, and to open up space for

\(^{26}\) Opening remarks of committee chair to public hearings

\(^{27}\) BC Liberal Party A New Era for Health Care
meaningful dialogue. They are accounting for their opposition to privatisation and profit-making.

In the previous chapter on the dominant framing was the reference to September 11 in the opening remarks to the hearings by the chair of the committee. Two coalitions of presenters express concern that the preoccupation with the events of that day and the aftermath has removed attention from real events closer to home, leaving issues that affect their daily lives ignored. The spokesperson of one of these coalitions speaks to September 11 from a completely different place:

We're here because we're concerned about the health of our community, especially of the most vulnerable. September 11 and the aftermath events have drawn people's attention away from events happening closer to home, such as all of the following, which have huge implications for the health of our community.

In summary, the strategies in this grouping speak to the effectiveness of the dominant framing. The permeation of the concepts and language of the dominant framing in the counter framing is palpable. While presenters experience the effects of the dominant framing, they make significant efforts to reveal the contradictions therein and contest their assumed meaning.

**Exposing the Manufacturing of the Dominant Framing and Re-politicising the Debate**

Intriguing as an act of citizen resistance is a group of techniques employed infrequently but forcefully and persuasively. While most presenters speak to the concepts of the dominant discourse, presenters using these strategies speak *about* the dominant discourse: how it is produced and how it operates. They demonstrate just how they see the dominant framing constructing and controlling the limits of the debate. Perhaps employing the boldest of the strategies, these presenters name the techniques of domination used to influence the governed. Placing the debate in the political arena, presenters make links between political decisions locally and globally. The following table lists the strategies in this fourth grouping.
Table 12: Exposing the Manufacturing of the Dominant Framing and Re-Politicising the Debate

<table>
<thead>
<tr>
<th>Techniques:</th>
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<tbody>
<tr>
<td>• Expose workings of dominant discourse</td>
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<tr>
<td>• Exposing and counter framing costs</td>
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<tr>
<td>• Linking local with global</td>
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<tr>
<td>• Linking health care with other political decisions</td>
</tr>
<tr>
<td>• Exposing myths</td>
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<tr>
<td>• Making allegations</td>
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<table>
<thead>
<tr>
<th>Purposes:</th>
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</thead>
<tbody>
<tr>
<td>• demonstrate the dominant framing</td>
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<tr>
<td>• <strong>constructing and controlling the</strong> limits of the debate</td>
</tr>
<tr>
<td>• name the techniques of domination</td>
</tr>
<tr>
<td>• expose myths; attempt to discredit them</td>
</tr>
<tr>
<td>• draw on entirely different discourses in their interpretation of costs and offer a re-framing beyond a financial definition</td>
</tr>
<tr>
<td>• open up the debate to be inclusive</td>
</tr>
<tr>
<td>• speak to the causes of illness, to the determinants of health, to the social realities of people the world over, to the effect of policies, laws and political and corporate agendas near and far</td>
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**Exposing the Workings of the Dominant Discourse**

A presenter who is much more timid than others offers a clear example of how the dominant framing works. Even though she poses a question, she likely already has an answer figured out as she comes to understand the dominant framing. She states: "My hope is that you’re not doing this with the intention of presenting a private system as the only solution. That would be unacceptable." Another presenter is more forceful in his accusation as seen in the following table.
Table 13: Example of How the Dominant Discourse Works

Instead of protecting health care, our federal government, which seems to work not for the people of Canada but for the corporations of Canada, has deliberately starved the system of funding in order to place it under increasing stress and make it malfunction so that Canadians will lose faith in it. We can see this in our own media here in Victoria and in B.C. and in the governments, provincial as well as federal. [...] These people can see that there are huge profits to be made, like there are in the United States. Therefore, they fully intend to privatize the system and take those profits. [...] We’re been told over and over again that the national debt was caused by overspending on social programs. [...] We’re told that private hospitals will be cheaper or save money in unspecified ways. We’ve certainly been told enough times by the corporate media that the government can’t run anything. [...] Is there enough money in Canada to adequately fund a first-rate public health care system? Of course there is. There’s so much money that you guys just gave a huge tax break to your friends in the upper-income and corporate communities, and the Chrétien government just gave the largest tax break in Canadian history—some $100 billion over five years with somewhere in the neighbourhood of 60 percent of it going to the highest-income 10 or 15 percent, who need it the most. [...] Of course we can afford health care for ourselves, except that we have this huge national debt. Because of the debt and the deficit and the big interest payments, we don’t have enough for health care and other social programs.

The presenter in Table 13 identifies what he believes is the hegemonic workings in the messages we hears including that government and corporations have joined forces to ensure that profit can be made. Recognising that health care can be very profitable (in Canada, millions are made on pharmaceuticals, for example and in the US, billions of dollars in profit are made on hospitals, managed care corporations and private insurance28) governments, including our own, have given health care contracts to corporations that intend to privatise and make those profits. And finally, he challenges the rhetoric that there is not enough money. This example illustrates the combining of strategies as it points out a contradiction in the rhetoric and exposes the construction of a story for a particular purpose.

**Linking Health Care with Other Political Decisions**

The connection between political decisions has not escaped these presenters. While the dominant framing only refers to actions of the previous government, several

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28 Fuller 113-117, 142-143.
presenters make the link between decisions of several governments (not just one particular governing party, although some do that as well) and what they see as problems in health care. The two most often referred to are decisions around tax cuts and trade agreements. One presenter gives the government permission to retract the tax cuts, another requests no tax shelters for private corporations. Both of these requests are made so money can be redirected back into the public purse to, as one individual presenter who has experienced the drawbacks of private for-profit care facilities says "open up seats in colleges and universities for students graduating and planning on entering the medical field; direct public money to the community to ensure a continuum of service to the clients, thereby freeing up beds in acute care hospitals".

Another presenter who works as a medical social worker compares the severance package given to a Deputy Minister of Health Planning to the minimum wage of $8 an hour, implying injustice. Making clear what he believes is the fallout of one political decision, he also exposes the ironies in how particular dollar figures are frequently presented. He says:

the usual figures released in support of radical restructuring are based on percentages of government revenue going toward health and projections that take into account falling government revenues. And direct cost of falling government revenues is tax cuts that were initiated, ironically, to stimulate economic growth and, ultimately revenues.

A team of presenters, the CEO and acting Board Chair of a Health Council, are closer to the committee in the health care hierarchy than most other presenters. They oppose privatisation and profit-making but are quite strategic in their comments. They also speak to the ethics of making tax cuts: the end does not justify the means and is contrary to the government’s and the committee’s stated intent.

While we agree in principle with the need to balance the provincial budget in light of the current economic downturn, we cannot support the loss of any of our existing core health services in order to achieve this end. […] The health needs of our populations do not shrink along with our diminishing budgets.

**Linking Local with Global**

Many presenters refer to trade agreements such as the North American Free Trade Agreement (NAFTA), arguing that "once a service is gone, it is gone". One presenter,
who speaks on behalf of an advocacy organisation as part of a coalition, expresses their worries: "The fear is real that a private hospital will cost more to operate and thus will take scarce health care dollars away from this region. The [A] hospital is not an isolated problem. It involves provincial and federal jurisdiction, along with free trade concerns within the global community." While forms of privatisation are presented as inevitable, desirable, and easy and problem-free in the chair’s opening remarks, many presenters know it is not that simple, that opening up our system to the private sector will have long-term, perhaps irreversible impacts. Expansion can be prevented now but it may be impossible to reverse in the future. Canada, especially B.C., cannot stand alone but must consider the relationship between our decisions here and those around the world. Short-sighted decisions will not necessarily be good for the long term. Says the chair of a health council board: “We need to act locally to create healthy people living in healthy communities while thinking globally about living in a healthy world.”

_Exposing Myths_

The health council board chair quotes a list of myths and corrections to them provided by The Canadian Health Association, perhaps a credible source in the eyes of the committee, myths that lead to the kinds of discourses seen in the dominant framing of this hearing process. This technique of listing and debunking common myths demonstrates the presenter’s understanding of the complexities of funding and administration. He distinguishes between public and private spending, which are simplified in the dominant framing. His purpose, he says, is to “to tease or separate out the facts from the background noise”, background noise that instils fear, controls the debate, and convinces many people that privatisation is necessary. This presenter implies that the committee is relying too much on, and perpetuating, myths.

Myths are presented and disseminated by imbedded authorities, media, and business sectors in particular ways so as to contribute to the production and re-production of the dominant discourse, an example of Foucault’s technique of domination. Sometimes a grain of truth is manipulated, used incorrectly, or taken out of context to garner public support. Portrayed as evidence and knowledge, misinformation is repeated in particular ways, myths are taken as truths and become taken for granted, part of the dominant
discourse. Opinions are formed and decisions are made accordingly. This presenter warns against falling for this kind of manipulation. By debunking the myths, he attempts to open up space for different “truths” that have been ignored or silenced. By exposing them, he demonstrates how the dominant discourse operates deliberately and seductively to convince, to pull people into believing mistruths to which privatisation is believed to be the solution. That so many presenters to these hearings appear to believe these myths, some of whom support privatisation and profit-making as a solution, suggests the success of the framing and how those presenters participate in the creation and affirmation of the dominant framing.

Re-framing Costs

In this consultation process on health care in BC, the dominant framing maintains a narrow definition of costs as strictly a financial concern: how to reduce, how to deal with an alleged overrun, how to decrease demand. Within this focus, there are assumed understandings: that costs are only measured in dollars, that they are out of control and need to be controlled, that there are particular ways that this controlling should be done, and once controlled, the health care system will once again be well. Bourdieu calls for a calculation of the social costs of economic-based decisions and presenters provide plenty of examples of costs that are ignored when economics rules decision-making processes. Many presenters reject how financial costs are calculated and argue for a broader understanding of costs. Some draw on entirely different discourses in their interpretation of costs and offer a re-framing, highlighting diverse understandings, varied definitions, and multiple experiences of the costs, financial and otherwise, of privatisation. They attempt to shift the commitment from a “dollar lens” to a “human lens” that is multi-dimensional: one that first considers the impact on people and may consider financial costs. Sometimes, the interpretations of costs overlap; a high price for a person in terms of independence may also be costly in terms of dollars.

Many presenters stick to the dominant understanding of costs as financial but challenge the idea that costs need only to be reduced. They argue that doing so in one area only increases financial costs in another area, such as choosing between medication
or food, caring for family members or working a second job to pay for health care services, or reducing home care resulting in someone requiring facility care, for example.

By exposing the costs of privatisation, profit-making and the impacts of the dominant discourse, presenters are doing what Bourdieu suggests: they are “reflect[ing] on the implicit limits which economic theory accepts”. Economic theory, he says, only deals with financial costs and does not take into account social costs. Yet, the social costs often result in more serious, immediate ramifications to individuals that are buried under a preoccupation with financial costs. Often presenters do this re-framing of costs within the concepts of the dominant discourse to appeal to the committee’s sensibilities. Presenters want to show that the committee’s goals of achieving efficiencies and cost-effectiveness are compromised by certain policies and are costly in other than financial ways. According to the man who identifies himself as a business man:

Their goal once again, in the private sector, is profit and the best return for the shareholder. It's not the best return for the stakeholder, which is the province or the citizens of British Columbia. I think that the public sector employees are a valuable part of our health care team, and contract services do not bring the same dedication. I challenge the promoters of outsourcing to total and compare the costs and benefits before they move forward on something like that. The problem I see is a lot of people approach it as a narrowly defined accounting problem—oh, here’s our cost. Anyone can run a spreadsheet these days. They’re pretty easy to work with. Punch in your numbers, get your figures, and there you go. That’s only what’s hitting the balance sheet. It’s not what’s hitting the other costs outside that area.

To end this section on the fourth set of strategies, the identification of the production and the operation of the dominant discourse is a technique of opposition unique amongst the many strategies employed. Those who engage in this exposé join others who draw the links between many political decisions and the problems facing health care. This re-politicisation of health and health care is in direct opposition to the committee chair’s attempt to depoliticise it. She wants to distance the government and other decision makers from taking responsibility but the presenters are handing it right back.

29 Strong Medicine for Health Care
30 Bourdieu 39.
By linking the local with the global and linking various political decisions to health and health care, presenters are opening up the debate to be inclusive and thoughtful. These strategies resist the narrowing of the debate to one of dealing with cost overruns and attempt to broaden it to the many places these presenters believe it rightfully belongs. By broadening the debate, they are suggesting that the perspectives one brings to it and solutions considered must also be broad. It is an attempt to recognise that health and health care have many components, all of which must be considered. It is the push to have those other components addressed that adds to the politicisation of health.

Presenters remind the committee of the connections between people and intersections of discourse, policy, and human experience, both locally and globally. They are speaking to the causes of illness, to the social realities of people the world over, to the effects of policies and laws, and political and corporate agendas near and far. These broad-reaching linkages underscore the effects that many political decisions can have on health and health care and demonstrate just how political health and health care are. Many presenters also refuse the blame that is given them, subtly and blatantly, through the constant messaging that the public needs to take more responsibility and stop being so demanding. Rather, they are handing responsibility back to the political arena and the policy makers by exposing and resisting the effects of their discourse and decisions.

It is by understanding how the dominant discourse operates that we can begin to critically reflect on its effects and consider the possibilities for doing things differently, for the creation of a counter discourse. Given that “discourse refers to language, texts, and practices ‘that systematically form the objects of which they speak; they do not identify objects, they constitute them and in the practice of doing so conceal their own invention’ ”31, exposing its invention renders its power fragile which, in turn, makes space for the possibility of thwarting it through the creation of a counter discourse. A few presenters reveal its creation with the hopes of reducing the influence of the dominant framing on the counter framing.

31 Foucault in Jeffrey 15.
Attempting to Start with/from a Different Premise

Most of the strategies discussed thus far originate from a place of opposition, identifying what is wrong with the health care system and how people's health and health care is negatively impacted by particular discourses, practices, and policies. However, this opposition is done within the dominant framing as presenters resist by providing opposing views or angles to consider, putting a different spin on the concepts that are used within the dominant framing. They share at least a few of the assumptions of the dominant framing: that cost savings, responsibility, accountability, and reform, for example, are necessary. Alongside these strategies are a final group of strategies that attempt to insert a different premise, outlined in Table 14. Rather than only agreeing with the dominant framing about what the problems are and shedding a different light on them, a few presenters direct listeners to focus their attention elsewhere. The presenters employing these strategies draw on different values and principles than those they believe are driving the debate and they try to insert them into the debate to influence the discourse.

Table 14: Attempting to Start with a Different Premise

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<tr>
<th>Techniques:</th>
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<tbody>
<tr>
<td>• Making Suggestions and Recommendations</td>
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<tr>
<td>• Drawing on a Broad Definition of health</td>
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<tr>
<td>• Proposing Counter Ethical Arguments and Values Statements</td>
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<tr>
<td>• Issuing a Challenge</td>
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<tr>
<th>Purposes:</th>
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</thead>
<tbody>
<tr>
<td>• assert values and principles different from those they believe are driving the debate</td>
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<tr>
<td>• insert these values and principles into the debate</td>
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<tr>
<td>• originate argument from place other than dominant framing</td>
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Making Suggestions and Recommendations

The invitation to the hearings calls for “proposals and recommendations for improving the B.C. health care system”. Many presenters respond to this request and offer a variety of suggestions. Some proposals, such as a fair taxation system, are made in opposition to something the presenters do not like, for example, user fees. The community coalition focuses its presentation on home support and provides a list of
recommendations such as restoring home support levels, lobbying the federal government to return to paying a much higher share of health costs, and urging the federal government to retract the pharmaceutical patent protection. Proposals like these three are in reaction to the dominant framing. This same group goes on to add other suggestions that are not reactionary but begin from a different place than the dominant framing, almost visionary, such as promoting a national home care strategy and enhancing home care nursing and more centres like the nursing centre in their area. Rather than reacting, these examples attempt to open up space for how the public system could work differently and be improved, rather than merely protected or saved. The acting health council chair and CEO offer their own suggestions:

The key, we believe, is developing a system of primary health care that focuses on delivering care by the right health care provider at the right time and in the right location. [...] We strongly support the creation of truly integrated interdisciplinary health care teams that would bring together a range of providers to deliver everyday health services. Bringing together family physicians, nurse practitioners, public health and home care nurses and other health providers would provide this coordinated system of care.

The kind of suggestions these presenters offer do not appear in the dominant framing. They would likely be acceptable to Mathieson, the theorist imaging the alternative, because they are unfinished, they are in contrast to the dominant framing yet they are incomplete enough that the committee cannot reject them outright.

One individual presenter puts forward a couple of innovative suggestions. “The proactive health care initiative that I’d like to advance is one that I like to call: eat your vegetables, B.C. [...] Another idea that I have—and this one sounds way out there, I know—is for reducing tobacco consumption.” With both of these suggestions, he goes on to describe the details of his proposals. In Mathieson’s terms, suggestions like these are so complete and so contrary to the dominant framing that they are easy to dismiss even if they hold elements that may be useful. However, that they are completely outside the dominant discourse makes them unique as a strategy of resistance. This presenter has ignored the dominant framing and come with his own ideas, even if they are “way out there”.
**Drawing on a Broad Definition of Health**

Another concept this last presenter points to is the determinants of health. Good health is not dependent solely on a good medical system but is interdependent with many aspects of life. He is referring specifically to diet. The acting chair of a health council speaks to the determinants of health directly. The following excerpt from his presentation also represents the overlapping of strategies as he deals with both the determinants of health and linking the local with the global from the previous strategy grouping.

In our quest for health, we recognize that most of the major determinants of health lie beyond the mandate of health authorities or for that matter the provincial government. It’s a generally accepted fact that our health system only impacts 20 percent of our individual health. Primarily, health results from our genetic inheritance, healthy development in our growing years and making the right healthy choices in life. However, these determinants are directly linked to our individual socioeconomic status, the quality of our communities and our environment and are in turn influenced by our cultural values, by provincial, federal and global economies and ultimately by the health of the global ecosystem.

Presenters speaking to the determinants of health are approaching this debate using a broader definition of health than appears in the dominant framing. Health care is more than just treating illness. The acting chair of the health council places responsibility for health well beyond the capacity of individuals, sharing it with local, provincial, and international governments and linking it with values and political decisions. This statement is in contrast to the committee’s chair who places responsibility for health in the hands of “patients and their families”. This attention to the determinants of health is absent in the dominant framing.

**Proposing Counter Ethical Arguments and Values Statements**

There are many ways of understanding the rights and responsibilities of citizenship. Both the dominant and counter framings speak to political citizenship, the right—and obligation, according to the dominant framing—to participate in decision making. However, the presenters also speak to social citizenship. The dominant framing appears to have certain assumptions of what those might be, evident particularly in the words of the chair before most hearings. Believing them unethical, presenters react to these assumptions with their own moral and ethical considerations.
Jenson has come up with two ways of understanding social democratic equality of participation:

- (f)ostering and ensuring equal access to market incomes, through regulations, education, training and employment policies. It also means reducing dependence on market income, so that citizens can enjoy similar levels of services and benefits, no matter their earnings or the source of their income. The first implies that all citizens will have the capacity to exercise a key social citizenship responsibility, that is to pay their taxes. The second implies that all citizens will be able to enjoy the entitlements that come with citizenship.32

Presenters argue against the ethics of the dominant framing. Jenson’s understanding is taken up by presenters who demand that the tax cuts be revoked in part so that health care can be properly funded and remain a publicly delivered and funded service and by presenters who argue that access to quality health care for all people is removed by the demands for profit.

In contrast to the absence of public in the opening remarks to the hearings, one presenter representing a union speaks about health care only as “public health care”. He has taken note of the absence (or removal) of key words from the discourse shaping the debate and he re-inserts them, making public health care a right of citizenship. That health care can be anything but public is not an option to him. So, rather than admitting that the future of public health care is in jeopardy, he talks about the values of a public system. He is standing for as much as resisting against when he says: “(We) want to state unequivocally that health is a fundamental right for all Canadians. By that we mean public, not for-profit, health care. I want to emphasize the commitment of, I think, the majority of Canadians to that fundamental concept.” Another union leader speaks to what he believes is inevitable in a system where any manifestation of privatised health care exists—inequities that are contrary to his moral standards and values, his understanding of citizenship.

The promise that we made to Canadians and British Columbians in this province was that everybody was important and that nobody got to be more important because they had more money. They were important because they were citizens of British Columbia. I made that promise. In

the labour movement we intend to keep that promise, because the alternative doesn’t work for us. The alternative is letting people go ahead of other people because of their economics. That will mean the lineups get longer and longer for everybody else.

That he represents thousands of people in B.C. means that these values may be shared by many. While such values may have existed in the text of the BC Liberal campaign platform, they seem to have disappeared by the time the chair of the committee makes her opening remarks to the hearings.

Summary

The tensions in the literature surrounding the concepts of public consultation and participation, and resistance are evident in this research. The theorising of resistance suggests multiple ways to consider the concept and the results of this research concur. There are various and diverse strategies of resistance employed by these presenters. They overlap, intertwine and come at resistance, sometimes with cross purposes. At the same time as they attempt to deconstruct and disrupt the dominant framing, they construct a counter framing that fits with their varied values, principles, and experience. Their strategies are attempts to mobilise attention to particular understandings not visible, or made invisible, in the dominant framing. They attempt to counter the effect of the dominant discourses and to expose their invention and harm.

Although drawing on different values and understandings than the dominant framing, presenters who try to insert a different premise have difficulty doing so without referring to the dominant framing. Frequently, they speak for rather than speaking against. But the dominant framing is never far from their minds. This tension exists among theorists of resistance and demonstrates the effect of the dominant framing.
Chapter 6: Preserving the Dominant Framing

Most people would assume there would be some dialogue in hearings such as the ones at the centre of this inquiry, at least in the form of questions to the participants for clarification, given that public consultation processes are allegedly about seeking participation and input in determining the direction of public policy. Questions or comments indicate that the committee holding the consultation has listened to a presentation, absorbed its content, and understood it enough to give it due consideration. The dialogue gives a presenter an immediate sense of how the committee heard the presentation whereas the final report indicates whether or not the committee took up any of the content and if so, how. The dominant framing that greets the presenters who speak to the public hearings is not complete but is a process that continues to work throughout the hearings. Exploring the dialogue reveals the framing process still in development.

A unique feature of this research is its investigation of a consultation process in real time as it is represented in transcripts. Visible is what occurred in the moment, even if after the fact. I expected to find dialogue between presenters resisting the committee’s framing of the issues and the committee members, but there is very little. The absence of dialogue is somewhat surprising. Of the 11 potential committee members, one is a member of the opposition party who did not attend any hearings because she is one of only two members in opposition in the legislature and her energies are stretched thin. Noteworthy is that of the ten remaining committee members, five asked most of the questions, the rest said very little.

Interesting patterns nonetheless emerge from the transcripts. Even the absence of dialogue is instructive. Most presenters are asked no questions, some hear a comment or two. Even the longest presentation made by a group of seven people, each representing a different organisation or union and each speaking from a different perspective, received not one question from the committee. There appears to be no interest in this group presentation even though thousands of voices are represented. There are two presentations that garner the most response from the committee. One is the only presentation from anyone holding a high level position in the health care system in B.C. who resists the dominant framing, a co-presentation by the CEO and the acting board
chair of a health council. The other is a professor of nursing at a university. Her status as professor and researcher likely gives her credibility in the eyes of the committee. The committee engages with these presenters at an entirely different level than they do with all other presenters, in fact, it is the closest they come to meaningful engagement. The different levels of engagement may indicate the different values given to particular participation. Table 15 lists the strategies the Committee employs when it responds to the presenters.

Table 15: Strategies of the Committee to Preserve the Dominant Framing

- Thanking the presenters
- Placing the opposition on record
- Reinforcing the need to manage the money
- Reprimanding and dismissing
- Attempting to neutralise the dominant framing
- Dis-engaging

Thanking the Presenters

The most obvious pattern emerges quickly: after making their presentations and in some cases, explicitly asking for questions, most presenters are greeted with nothing more than a “thank you” from the committee chair. Some presenters receive a compliment or two, such as “I want to compliment you for tackling this in a way that addresses the issue head-on. You’ve laid out recommendations, and we appreciate it.” This comment and others like it speaks to the organisation of the presentation or the written submission, not to issues raised. There is no mention that the content will be taken up seriously. For many presenters, these kinds of comments are the extent of the interaction between them and the committee.

“Thank you very much for such an informative presentation” says the committee chair to one presenter, a social worker working in a hospital. It is hard to assess the meaning of “informative”. The chair challenges the social worker on the numbers he uses and puts forward the statistics she prefers. He counters by suggesting that the numbers she is using lack the perspective the numbers he uses have and thus, give a skewed sense of reality. After his clarification, the chair offers her thanks. He has called her on a key strategy on which the dominant framing relies, a particular use of numbers to prove a
crisis. Whether the chair accepts his interpretation of the numbers or whether the committee really uses it to “inform” their recommendations is unclear. She offers no indication that she understands, agrees with, or accepts his analysis.

**Placing the Opposition on Record**

The chair assures a couple of people that their comments are now in *Hansard* or on official record. “Hopefully, now that you have read these particular statistics and articles into *Hansard*, they will be public knowledge.” These comments may be dismissive; while having their resistance recorded does serve a purpose, presenters come to these hearings to be heard and to influence decision-making, not just go on record. Additionally, she is giving preference to the parts of his presentation that put forward statistics and literature that are compiled and authored by “experts”—thus credible and record-worthy. There is no indication, however, that this evidence will actually inform their recommendations. To be relegated to the record books suggests that being on record is the only value their words will have.

**Reinforcing the Need to Manage the Money**

The social worker who receives thanks for his “informative” presentation makes direct allegations, exposing the contradictions in the dominant framing. For example, he alleges that tax cuts, justified in part to stimulate economic growth and revenues, have actually resulted in decreasing revenues. The figures that are used to demonstrate this decrease are then used to support the need for privatising to allegedly create efficiencies and cuts to health care budgets, breaking election campaign promises. This presenter uses research of the Canadian Institute for Health Information (CIHI), likely viewed by the committee as a credible source, to make his point. The figures he uses to reflect what he thinks is the real picture represent percentages of the change in the cost of health care versus actual (raw) numbers which he says are misleading as stand alone figures. At the end of his prepared presentation, the committee chair speaks before inviting other committee members to ask questions. She wants to clarify a few things, perhaps for the record, and corrects his numbers. First, she notes:

The difference between the $9.5 billion budget, which remains, and the $300 million-and-growing overbudget that we have to get back into proper
perspective. That is where the cuts are coming – to manage that $300 million overbudget. [. . .] That kind of growth and trajectory into outer space is something that the country let alone our province, can’t maintain.

She quotes numbers from CIHI as well, comparing actual dollars spent in 1975 to those spent in 2001. Her choice of numbers are the ones the presenter has just alleged are used to justify privatisation and budget cuts because they do not provide a context or true comparison. She misses his point and prefers to continue to draw on the discourse of unsustainability. The presenter, so as not to annoy the chair, agrees that “the numbers, certainly, are absolutely frightening” yet counters this challenge by referring her to more CIHI numbers which are an analysis of the actual numbers in percentages, thus putting the actual numbers in perspective, in a comprehensible way, demonstrating a different effect than her numbers. He offers this counter point politely and thoughtfully. The chair then thanks him and his time is up.

In this exchange, the chair accomplishes several things. First, she makes clear the mandate of this committee: to put the budget and overbudget into perspective. She does not say what this perspective is, however, but one can assume it means reduce it before it ends up in “outer space”. It is clear that the overbudget is of primary concern. Second, she continues to do what the presenter has suggested is problematic, use actual numbers out of context which are then used to justify particular decisions. She has not heard his critique or ignores it. She expects her perspective to be acknowledged but she refuses to acknowledge the perspective he puts forward. The veiled reprimand, pulling the debate back to the where the committee wants it, keeping the fiscal discourse as the centre, and closing the debate are not atypical of the committee’s responses to other presenters. The reassuring point about the chair’s comments is that she shows that she actually has listened to what he had to say. However, when he tries to inject the dominant framing with a different light, he is shut down.

Other committee members refer to the financial unsustainability of health care. One denies that it is a myth that health care spending is out of control, an argument that misquotes one presenter who lists the myths the Canadian Health Association discredits. He rolls four myths put forward by the Canadian Health Association into one and in the process confuses four measurements of spending: total, private, and public spending, and health spending relative to the GDP. This confusion of the issue is one strategy to allege
certain truths in a way that seems believable when not deciphered. The committee member goes on to narrow the issue further to one of the alleged $300 million overspending, but over what, he (nor the chair earlier) does not say. He offers incomplete information before putting his real interest forward by saying “unless there are some dramatic cuts, we are going to see a doubling or more than a doubling since 1992 of our health care budget in this province”. This comment is the first reference to “cuts” after the use of many terms such as “solutions”, “suggestions”, “improve”, “sound”, “adequate”, “restraint”, “efficiencies”, “sustainability”, “renew”, or even “reform”. This committee member is blunt in his reminder of what is likely the real interest of the committee and puts a shadow on all those other euphemisms.

The presenter to whom the committee member makes these comments says he voted for the BC Liberals because they promised to do things differently yet they are now into “how can we cut, slash and burn?” The chair corrects his language and states that in her terminology, the words are “mend and bend, not slash and burn”. The committee member who previously stated he was looking for ways to dramatically cut, tones down his rhetoric too, to “we’ve got to find quick methods to stop the spiralling costs”. The use of language massages the message.

The health council CEO and acting board chair are quite clear in their oppositional stance to privatisation and profit-making and the myths that are driving decision-making. But as the committee engages with them, they soften their approach somewhat. They recommend the government perform “surgically precise cuts” and become aware of how politically astute the public is, a public who, they argue, deserves dialogue and information. Their job and appointment respectively rest with the government so they seem to limit the amount they push this committee. However, given their position, their resistance is significant.

At one point, *Hansard* notes that people in the room applaud the acting health council chair’s comments: “How are you going to tell me that the slash and burn is any different than what the Socreds did before and what we were promised many times by the NDP, and so on and so on? It’s the same approach to these problems. It didn’t work then and it’s not going to work now.” The committee chair retorts: “And we can actually attest to that. We know, and we’ll clap for that too.” Except to correct his terminology, she
sidesteps the comment completely by seemingly applauding the criticism of the NDP and ignoring the challenge to her own government.

**Reprimanding and Dismissing**

Presenters who are critical of government and make allegations, for example, that the government is manipulating citizens into believing the health care system is unsustainable, do not get challenged by the committee for their criticisms. An exception, however, comes from the chair, mid-way through a presentation, when she interjects to remind a presenter that the committee is an all-party committee, that there is a member of the other party on the committee: “I just wanted to make everybody aware of that.” This admonishment is in response to the presenter’s allegation that “your government” is meeting in secret. The chair is in effect criticizing the member of the two-person opposition for not attending committee meetings. She is also reprimanding the presenter for criticizing the government for its closed door approach by reminding him that there is no “your government” because this committee is all-party. She does not acknowledge that this other committee member is one of only two members of the opposition in the house and, as such, sits on multiple committees and cannot possibly attend all meetings of all committees. It is very likely the presenter is well aware that, officially, there is a member of the opposition on the committee. The chair is making known her displeasure at being told off.

Several of the committee’s comments are similar in tone to this reprimand. Comments such as “We get your point”, for example, and “I would like to draw attention to the fact that we’ve actually heard from a number of folks in your field” sound dismissive and do not instil confidence in the presenters that their comments are being taken seriously. They appear to be attempts to minimise or even silence the speaker.

Presenters come to these hearings aware that they have limited time. Should they forget, however, the committee is sure to remind them. “I’ll just ask you to wrap up, if you could. Thank you.” The presenter has no choice at this point but to do what is asked of him. Time becomes a tool to keep people in line and a justification for not engaging with the presenters or their ideas, preserving the dominant framing.
**Attempting to Neutralise the Dominant Framing**

One committee member asks a similar question of two presenters, enquiring if private-public partnerships would be an option to consider if their respective concerns could be alleviated. To a health care worker in payroll for 20 years who expresses concern that people who can afford to pay for tests will jump the line if given the opportunity, the committee member asks “If a system could be designed, though, that prevents that and actually shortens the list […] and you could be assured that queue-jumping doesn’t occur […] would you be supportive […]?” The health care worker denies that is an option, responding succinctly: “No, I do not believe that profit has any place in health care. The right to be healthy is a right. It is something we have that Canada needs to be proud of. I do not think it should be done for-profit.”

After the CEO and acting board chair of the health council speak strongly against privatisation and profit-making in their presentation, the committee member asks the board chair about the feasibility of finding efficiencies by privatising service delivery but maintaining a publicly funded system. The board chair is more receptive to this possibility than the health care worker, saying that: “as a lay person and a member of the public, I do not care who builds the building as long as you can show me that the services I’m being given are at a reasonable rate. Everything else is copacetic. I’m fine; I’m happy with that, but I’m getting nothing right now.” His co-presenter, the CEO, quickly jumps in: “I’d like to just add to that, if I could…” and proceeds to give evidence in the form a story from a colleague about a public-private partnership that is problematic. He does not want the committee to think they would be comfortable with private-public partnerships with just a promise that everything would be okay.

The rhetoric and approach the committee member uses appears respectful but may also be a way to attempt to neutralise the issue or trap the presenters. For example, the committee member asking the questions to the health care worker plies her with gratitude and compliments before he asks this question. Additionally, the question is asked to both presenters in a way that makes private-public partnerships appear to be a neutral solution that would serve no harm if gone about in a particular way. It is meant to sound good, logical, and hard to oppose as he leaves out the distinction of public management made by other presenters. Instead, he highlights that the services would continue to be publicly
funded. This slant is a common one, omitting the fact that those public dollars will end up as profit in the hands of a private person or business. It is also put forward as a logical solution to the problems in the system as the committee member “assures” that the presenters’ concerns will not come to fruition. This technique is a good example of the kinds of strategies that are used in the process of the dominant framing: dress privatisation and profit-making up as a harmless, logical, and progressive solution. These two examples demonstrate how effective this strategy is as the acting board chair weakens his strong oppositional stance, only to be rescued by his co-presenter.

Several presenters refer to the private building and ownership of hospitals, making a link between permitting such privatisation and the NAFTA (North American Free Trade Agreement) that would make it impossible for any new hospital to be built only with public money that is not subject to challenge by private health care corporations. One presenter appears tentative, asking the committee for clarification to determine if they understand the ramifications of these kinds of trade agreements. The chair’s answer is a bit of a ramble but she tries to alleviate the presenter’s concerns by saying the privatisation would only be with the physical building, not the operation “at the present moment”. She compares his question to the water-purification issue facing municipalities, adding that people are looking into that problem “so that it doesn’t enter into the mix” like they did when “Europe, with the Euro government – Britain and the rest ran into that problem”. There is precedence out there, she adds. Her attempts to minimise the concern, which is a serious one for many presenters, do not work with this presenter. The following excerpt from Hansard illustrates the continuing concerns:

Presenter: [. . .] Any privatization of services, then, can be challenged by private health care corporations. So decisions that are made now in terms of privatization of services, buildings or whatever…. Then we're wide-open. Even if we make a determination at a later date that public buildings and public services are the way we want to go, we're then vulnerable to challenges under NAFTA. I appreciate what you're saying, but before we proceed in terms of privatization of services and buildings and everything, we have to know this absolutely, because it will affect us as long as Canada is a signatory to NAFTA.

Chair: Yes, you're right.

Presenter: Correct?

Chair: Uh-huh.
Presenter: That's all I want to say. Thank you.

Chair: Thank you for getting that on the record.

Two other committee members take up his point, however, and rationalise the existence of what he refers to as P3s by saying they exist already in education and nursing homes, insinuating that if they exist already, they must be all right. None addresses the real concerns of this presenter. This example depicts the strategies of the committee to de-contextualise, avoid, shrug off, minimise, and de-value the concerns of presenters, all attempts to maintain their argument that increased privatisation is workable and nothing to worry about, ignoring evidence to the contrary. These arguments are in keeping with the overall dominant framing that the system needs these kinds of solution to survive.

Dis-engaging

One of the strategies of many presenters is to call on the committee to take seriously their alleged commitment to public consultation. Accompanying an apology, one presenter challenges the committee to:

- respond to these proposals rather than the usual response of standing committees to thank witnesses for their contribution and ignore the input that does not coincide with their preordained agenda [. . .] And I apologize—this committee seems to be a little more receptive, on the surface anyway, than the previous committee that I spoke to.

However, the committee does precisely what he predicts they would do. They do not respond to his proposals but thank him and ignore his input which challenges the dominant framing. These actions are exactly what most presenters experience. Most of the presenters get little more than a thank you. The consultation is reduced to a time allotment.

Summary

Presenters have clearly put a lot of time and energy into their presentations and take this act of participating in the creation of public policy seriously. Yet the committee's responses come across as dismissive toward the presenters, their time, their words, their experience, and their participation as responsible citizens in this "consultation" process.
Dialogue in response to the presenters' ideas and suggestions takes a back seat to the realities of time constraints. Time becomes a tool to shut people down: your time is up. When the ideas are not what the committee wants to hear, the clock is pulled in as a way to shut people and their ideas down. Even though the committee, through its invitation and the chair's opening remarks, explicitly asks for suggestions, few of the suggestions they hear are taken up in any meaningful way in the context of these hearings. The two presenters who receive the most attention are professional and high-ranking people. Most are ignored completely. The silence is silencing: if the committee does not speak, the presenter must also stop speaking. These strategies are in keeping with the disciplinary nature of discourse in that the ideas, suggestions, and critiques that are not in keeping with the dominant discourses, thus unsayable, are penalised.

Yet the dominant framing continues to be reinforced by the compliments, the reprimands, and the silence. The comments that are made are usually about money as the committee reminds the presenters of their primary concern: spiralling costs. It is hard to imagine that most of the presenters who clearly oppose privatisation and profit making, many of whom were pleased to be part of the hearing process and even more pleased the government was following through with its commitment to hear from citizens, really felt heard or taken seriously during this hearing process.

While articulating appreciation for being consulted, presenters also speak about the kind of scepticism that many academics who theorise consultation and participation refer to. As the dominant framing is perpetuated in the engagement of the committee members with the presenters during and following each of their presentations, this scepticism becomes understandable. The tension revealed in the literature is experienced first hand by these presenters, many of whom come to the consultation table in good faith and may leave disheartened.
Chapter 7: Discussion

“Would-be challengers face the problem of overcoming a definition of the situation that they themselves may take as part of the natural order.”

This study explores the framing of debates within health care and citizen engagement with resistance to privatisation and profit-making of health care, in the context of a public consultation process in 2001 in B.C. This chapter discusses the arguments that can be made from the study’s discoveries. In brief, I wish to argue that the dominant framing shapes the debate and constricts participation and resistance to a very small space. Despite this small space, however, there is resistance. This study exposes this small space and discovers how inventive and varied resistance can be, even within a formal, structured, severely limiting context. I further contemplate the implications of these findings and explore how they might be taken up in other contexts.

Framing serves to highlight particular events, ideas, or parts of reality at the expense of others. Through the process of framing, as seen in key texts and the transcripts of the public hearings, the BC Select Standing Committee on Health and the legislature it represents present their understanding of the issues confronting the future of health care in B.C. Their dominant framing shapes the debate. The dominant framing is limited to fiscalisation, medicalisation, responsibilisation. It also alleges that privatisation and profit-making in health care is harmless and benign.

The transcripts I read were purposefully chosen because of their presenters’ stated objection to privatisation and profit-making in health care; it is how they construct their resistance in this public setting that is of interest. To be sure, resistance to privatisation and profit-making in health care occurs beyond the site of these hearings and is undertaken by many people on an ongoing basis. Nonetheless, regardless of how the

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2 Although, given the magnitude of the government’s majority, this committee, in a de facto sense, does represent the government.
resistance to privatisation and profit-making in this public consultation process is interpreted or analysed, these presenters did resist.

In examining resistance, my purpose is to understand, not to evaluate the success or the effectiveness of the resistance. Any commentary or critique must not be understood as a critique or measure of the presenters personally, their strategies, or the outcomes of their resistance. What is garnered in this research is an understanding of how the shaping of debates occur, what shapes and influences resistance, the possibilities of resistance in such a context, and what is important to be conscious of as a resister. This knowledge is beneficial to those interested in resistance of any kind but especially in the context of public consultations that are dominated by particular interests and agendas. It is also useful in understanding how it is that privatisation and profit-making are increasingly seen as inevitable and necessary components of our health care system. As seen in this study, there is a relationship between the framing of a debate and the possibilities for engagement with resistance.

The potency of the dominant framing makes resistance difficult. The initial discovery that there were only 22 out of 350 oral presenters to the hearings who spoke substantially against privatisation and profit-making may be indicative of the strength of the dominant framing, the barriers to participation created by the narrow framing, and the difficulty inherent in the challenge of resistance. The difficulty of this challenge is so aptly captured by Gramson in the quote on the previous page. The dominant framing begins somewhat broadly and hopeful with commitments such as “putting patients first”, which are repeated in the campaign platform and the invitation to the hearings. By the time of the public hearings, however, it is reduced to patient irresponsibility and out-of-control costs, leaving a small space to enter the debate. The hopefulness in the tone is thin, if there at all. The responses from the committee to those who challenge the dominant framing further constrict, leaving an even smaller space. Time to engage is limited, presenters are reprimanded and dismissed, and ideas that do not fit with the dominant framing are not engaged with meaningfully. This narrowing continues to shape attempts to create a counter framing. As the possibilities of debate are narrowed, presenters interested in contesting this framing may feel compelled to argue from within, or from what appears to be the “natural order” for there to be any chance of being heard.
The following statement, made by a presenter who goes on to create a counter framing, illustrates the effect of the dominant discourses on resistance, an effect that cannot be understated: “Yes, our system does need to be reformed. We agree with Dr. (M) and others who have said that our system is in crisis. We agree that we need to find cost-effective ways to meet our health care needs.” The discourses of fiscalisation, medicalisation, and responsibilisation become clearer, more specific, and more evident in the texts that represent the dominant framing throughout the chronology of this hearing process and are reinforced in the committee’s responses to the presentations. But they also are repeated by those attempting to create a counter framing. The participation of citizens who want to contribute to the debate, through resistance, is almost completely shaped by the dominant framing. But not quite. Regardless of the strength and influence of the dominant framing and despite the small space for resistance, there are some presenters who insist on engaging with resistance and come up with an impressive array of strategies and approaches. In this hearing process, the strategies of resistance are numerous, varied, and thoughtful.

This discussion puts forth the argument that the dominant framing narrows the space for participation as well as the possibility of positing counter ideas and engaging with resistance. Yet resistance exists and can be explicated using three concepts: personal responsibility, citizen participation, and resistance.

**Personal Responsibility**

Personal responsibility is a theme that threads its way through the dominant and counter framings as a shared value. Because it is held in such high regard in both, its place of prominence as a standard to meet persists. There is nothing inherently objectionable about it as a value and a practice so it is hard to argue against. For many, there is a natural sense of responsibility and desire to look after one’s own health or care for family members, for example. Few people need to be coerced into caring for their sick child. So, resistance to this notion is unlikely.

The space presenters enter into at the public hearings has been reduced to one where citizens, as users of the publicly financed health care system, are deemed irresponsible. “The age of entitlement ended on September 11. We can no longer demand
services as our due. We have to accept responsibility along with our rights. Even patients
and their families have responsibilities in using health services prudently.” Underlying
this statement made by the chair of the committee as a welcome and introduction to
almost every hearing is a paternalism and arrogance not yet seen in the dominant
framing. It supposes that citizens, “even patients and their families”, have been too
demanding and not responsible and this irresponsibility has contributed to a system that
now needs saving. Consequently, many presenters go to great lengths to demonstrate
their commitment to responsibility.

In these presentations, example after example of people’s actions and lives
demonstrate incredible responsibility, some despite the removal of health care supports
and services. Says one presenter:

I've worked as a long term care aide for 25 years, with the exception of
four years when I was at home raising my children when they were
younger. [...] I'm a survivor of a life threatening illness and I have had a
chronic disease since childhood. [...] With surgery and a healthy lifestyle,
I am here seven years later. I've been at death's door several times. [...] If
my parents had to pay for those visits and hospitalizations, I likely
wouldn't be here. As it was, my father had to work two jobs to pay for our
medication. He did his very stressful job in a jail and then went and was a
janitor to provide for us. In order to spend time with him, we went to his
janitorial job with him and helped where we could.

Like many others speaking from the standpoints of patient and family, this presenter
rejects the subject positions constructed for the unitary patient and family by the chair:
irresponsible and too demanding. Wanting to disrupt the dominant framing, they open up
a space for looking at and from these standpoints differently. Presenters are offended by
and challenge the insinuation that they are, in part, responsible for the alleged health care
“crisis”. They identify the significant level of personal responsibility they have achieved
in the face of, and in spite of, governments’ response to the so-called crisis.

Another presenter, speaking on behalf of a community coalition, suggests that
people’s ability to be responsible as patients and caregivers is diminishing because of
government attempts to improve the system and deal with the alleged crisis and
unsustainability by cutting financial costs. One could theorise and critique her emphasis

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3 Opening Remarks to the Hearings made by the Chair of the B.C. Select Standing Committee on Health
on the work of volunteers and the skills and knowledge required to provide health care, but that is not the point. She speaks as one bound by the framing to prove her responsibility. However, it is interesting to note that the committee member who had previously asked if volunteers could help in any way makes some assumptions about what kind of care—and thus what kind of caregiver—is required. He comes close to alleging that the level of personal responsibility now expected of people is that which used to be performed by health care professionals. His allegation is an example of false knowledge since a significant amount of care has always been completed by family and community members. Furthermore, it is an example of the downloading to citizens that Armstrong includes in her understanding of privatisation. Burchell says citizens are to “resolve the kind of issues hitherto held to be the responsibility of authorized governmental agencies”\(^4\). This presenter may or may not agree, but she does reject the allegation of irresponsibility. Presenters who are health care workers cite the contradictions facing workers daily. They are denied the time and supplies to do their jobs well, to be responsible workers. Nurses explicate the dilemma facing them daily: be responsible to management by reducing costs or be responsible to patients by giving good care. They cannot do both.

Citizens are told repeatedly that they have to be responsible, but what remains invisible—unspoken—are the responsibilities of the corporations that are contracted to provide care but do not appear to be held to the same standards. While citizens present evidence of their commitment to personal responsibility, they argue that governments, current, past, provincial, federal and those signed on to international trade agreements, are not demonstrating a similar commitment. The negative impact of NAFTA is a frequent concern and presenters suggest governments have been irresponsible to sign on to an agreement which may diminish Canada’s ability to provide good public health care, but these comments are ignored. Others make references to governments’ irresponsibility by creating policies that have the effect of reducing or removing the opportunity for citizens to be responsible, something for which they are then maligned. A spokesperson of a community coalition describes the situation facing an elderly woman in her

\(^4\) Burchell “Liberal Government and Techniques of the Self” 276.
community whose home support was reduced: “She does pay out of her own pocket now for somebody to come and clean house for her, but she had to cut out fruit from her diet because she couldn't afford it any longer.”

In the many references to and requests for community consultation and public input into policy decision-making, presenters are asking for more opportunity to participate. Participation is a key component of responsibility. There is incongruence between the rhetoric demanding more responsibility from citizens and the reality that the government is increasingly removing from people the possibility of practising responsibility at the same time as downloading it to them. The relationship between those who govern and those who are governed is confusing. The ability of the governed to meet the demands to control their conduct is made difficult if not impossible in certain circumstances for presenters. Yet, presenters are valiant in their efforts to participate. In the context of the narrowing dominant framing, the demand that people accept (even more) responsibility is an attempt to govern individuals by asking them to control how they conduct themselves and evokes the notion of governmentality. Citizens are encouraged to assume an “entrepreneurial form of practical relationship to themselves as a condition of their effectiveness and of the effectiveness of this form of government”\(^5\) and adopt a new relationship with government: stop demanding and take responsibility and the system will be saved. The many stories that demonstrate the level of citizen responsibility and the numbers of people who chose to participate in this hearing process reveal that people are, even if of their own accord, already complying with the request to be responsible and have adapted their conduct in accordingly.

“(C)ontemporary politics of competence construes subjects as, actually or potentially, active elements in their own self-government.”\(^6\) That this concept of personal responsibility is so prominent in people's daily lives, presentations, strategies of resistance, and interest in citizen engagement is in keeping with Peterson’s duty to participate and Burchell’s “responsibilization”. Citizens answer the call to participate in decision-making and have taken on the responsibility for carrying out activities formerly

\(^5\) Burchell “Liberal Government and Techniques of the Self” 276.
\(^6\) Rose 347.
the responsibility of governmental agencies. In asking for greater participation in
determining the future of health care in B.C. and in proving their current level of
responsibility (even over-responsibility), presenters have shown that governing has been
effective: presenters have been well indoctrinated in this value and ethic that has been
taken up in neo-liberalism. They have acquiesced and “freely and rationally” conducted
themselves in accordance with the appropriate—or approved—model of action.

That people want to be responsible and are trying so hard to be so in spite of the
barriers they face exemplifies the extent of the techniques of domination and of the self.
The practice of personal responsibility is an example of the “contact point” where
techniques of domination interact with techniques of the self. The dominant and counter
framings both provide excellent examples of both techniques. But the irony is that the
supposed goal of practicing personal responsibility may be unattainable through personal
responsibility alone. “Individuals may alter their relationship to themselves in their new
relationships with government, without it being clear that the outcomes that are supposed
to justify this rationality of government are in fact being achieved. And equally, they may
not.” Burchell predicts the contradictions facing patients, families, and health care
workers and these presenters offer confirmation. Personal responsibility is a paradox that
demonstrates that the binary of arguing within or without the dominant framing is not so
straight forward.

“They must take responsibility, they must show themselves capable of calculated
action and choice, they must shape their lives according to a moral code of individual
responsibility and community obligation.” Burchell’s “responsibilization” which pushes
people to participate in public consultation processes extends much further into the life of
a person and is now a fundamental component to the dominant framing: duty to
participate in the hearings, duty to be more responsible with health care services, and
duty to be responsible for one’s personal health. This shift away from collective
responsibility associated with the welfare state, something Bourdieu says is a

7 Burchell “Liberal Government and Techniques of the Self” 276.
8 Nikolas Rose “The Death of the Social: Re-figuring the Territory of Government” Economy and Society
25.3 (August 1996): 347.
“fundamental achievement of social (and sociological) thought”⁹, to individual responsibility is dominant within neo-liberalism. Under the guise of freedom of choice where you can choose between a menu of services and service providers and get the best health care service for you for the best deal, any notion of the state providing basic social welfare for its citizens is removed. Accompanying individualism is the possibility to “blame the victim”¹⁰ who is, once again, responsible for her own welfare and presumably irresponsible when she experiences poor health. With the argument that government can no longer do it all because the money is just not there, citizens are told to have less reliance on government. The dominant framing strikes all these chords. And the counter framing picks them up and runs with them.

Public Participation

This study is situated in a public consultation process, a frequently called upon method for dealing with issues of public concern. Participating in the development of public policy is viewed within a particular understanding of citizenship as an inherent right of citizens. White’s general definition of citizenship fits here: “(a) set of practices that allows a person to participate in the decision-making of her community. These practices include those activities that determine how resources should be used and distributed.”¹¹ The citizens of B.C. are not merely subjects to the power and authority of another. We are not powerless or passive, but “have the capacity and power to participate in politics, to act on [our] collective interests, desires, and goals”.¹² When decisions are made without public input, there are often accusations that decision makers are ignoring the interests and will of the people. And when consultation processes are held, regardless of the issue, there are usually some people interested enough to participate. The BC Select Standing Committee on Health’s hearing process is no exception, drawing the highest number of participants in the history of B.C.’s legislative committee hearing

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⁹ Bourdieu 7.
¹⁰ Bourdieu 7.
¹¹ White 56.
¹² Cruikshank 20.
Clearly, health care is high on the public agenda and people seem genuinely interested in joining the debate. This genuineness is evident in the presentations to the committee. Many thank the committee for the opportunity to speak. They hope—almost demand—that their comments and suggestions will be taken seriously, going to great lengths to achieve this goal.

However, the literature clearly reveals the concept of consultation as fraught with contention, its motivation not always so virtuous. Ableson et al's noted tension in the purpose of public consultation as informed, meaningful community decision making or "going through the antics of making the public feel that they have something to do with it" comes through clearly in the presentations of those resisting the dominant framing. Several presenters are bold enough to bring their scepticism to the attention of the committee, only thinly veiling their belief that the committee has the "preordained agenda" of promoting privatisation. Given the committee's responses to these concerns which constrict the debate further than the chair's opening remarks, Aronson's observation rings true: that the consultation process has preset limits and an agenda fixed within predetermined bounds. The idea that consultation is a democratising process is put into question by the narrowing restrictions of the debate. Presenters express their doubts and as seen throughout this research, their concerns are validated.

What exists, then, is the contradiction of people wanting to be consulted and the scepticism people have of consultation processes. The process at the centre of this study drew a record number of participants. What becomes evident is that acceptable participation is limited to agreeing to the dominant framing. While the small number of those who spoke substantially against privatisation and profit-making may be suggestive of the strength of the framing and the difficulty inherent in the challenge of resistance, it also may be indicative of the cynicism toward the exercise of "public consultation" that many of the presenters speak to. The cause of the cynicism is borne out in the committee's response to resisters and a circle is created.

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13 BC Select Standing Committee on Health “Patients First” 5.
15 Aronson “Giving Consumers a Say in Policy Development” 372.
Beyond the right or obligation to participate as a feature of citizenship, the understanding of citizenship is further questioned in this study with regards to entitlement. According to Brodie, post-war welfare states, of which Canada was one, "rested on a broad but ultimately fragile consensus about the rights of citizenship". The general consensus was that, along with the idea that the public could enforce limits on the market and that people were not forced to engage in market activities that denied their safety or dignity, the national community was responsible for the basic well-being of its individual members. Neo-liberal states are challenging this view of citizenship, especially the idea that everyone is entitled, as a right of Canadian citizenship, to state protection from unpredictable market forces and access to basic social needs of which health care is one. "Changing public expectations about citizenship entitlements, the collective provision of social needs, and the efficacy of the welfare state has been a critical victory for neo-liberalism." In her opening comments to 11 of the 14 public hearings of the BC Select Standing Committee on Health, the committee chair introduces privatisation and profit-making as an inevitable next step in health care. She also puts forward her own notion of citizenship as she questions the relationship between citizens and the state, specifically what citizens can legitimately expect from the state. Her version of citizenship significantly contributes to the narrowing of the dominant framing.

In a sense, I have been able to watch the narrowing of the debate taking place, in the midst of the consultations. This narrowing to a small space is a key finding. Remarkable, however, is that despite the strength of the dominant framing and the smallness of the space for citizen engagement, there is still resistance. There are some people who insist on engaging with resistance—in spite of the attempts to constrain them—and come up with an impressive array of strategies and techniques of resistance. They demonstrate their desire to act as citizens who participate in public debate and who argue that citizens are entitled to publicly governed and funded health care. In this hearing process, the strategies of resistance are numerous, varied, and inventive.

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16 Brodie 130.
17 Brodie 131.
Resistance

The effects of the dominant framing on the strategies of resistance are evident in the fact that much of the resistance is done from within the dominant framing. Presenters, for the most part, react to, even if they attempt to counter, the dominant framing. They speak its language and to its concepts. For example, an overriding concept in the dominant framing is that of financial costs. The texts depicting the dominant framing demonstrate considerable time spent attempting to convince the people of B.C. and each other that the system is in crisis and financial costs of health care are spiralling out of control and must be contained, all in keeping with an overall government preoccupation with deficitism. Presenters take up this preoccupation and speak to it at length. Whether they agree and offer solutions that will oblige the committee’s requests, disagree and point out the contradictions in the committee’s argument, or inject a different view of costs by arguing for a concentration on human, community, or social costs, the concept of costs remains a pivotal concept in the counter framing. To an even greater extent, responsibilisation is another concept that prevails in both the dominant and counter framings, as spelled out earlier. Presenters go to great lengths to demonstrate their commitment to personal and community responsibility.

The tension between “you cannot use the master’s tools to dismantle the master’s house”18 versus "every tool is a weapon if you hold it right"19 is central to theorising resistance. While there is no obvious conclusion, varied perspectives and rich arguments shed light on considerations of resistance. Bourdieu asserts that the only way to tackle the dominant forces20 is on territory familiar to them, particularly in terms of economics, and countering it by offering “in place of the abstract and limited knowledge which it regards as enough, a knowledge more respectful of human beings and of the realities which confront them”.21 He is willing to debate from within the dominant framing but

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20 in Bourdieu’s example, national and international technocracy
conditionally. Mathieson concurs, but adds that this familiarity must evoke uncertainty by proposing contradictions or the opposition will be dismissed. Conversely, G. Lakoff sees the strategy of speaking to the concepts and using the language of the dominant discourses as problematic. By doing so, he believes, resisters are perpetuating the dominant discourses and advancing the dominant framing.

These conflicting theories provide an uneven terrain from which to contemplate the strategies of resistance as seen in the presentations to the B.C. Select Standing Committee on Health's public hearings. Like others opposed to neo-liberal concepts, presenters to the hearings frequently use the language constituting those concepts, even if to redefine their terms. Some try to propose a re-conceptualisation to contest the dominant understanding. Others use language the committee will understand and listen to. Still others appear to use this language as an act of deference. Lakoff would suggest they have fallen victim to the dominant framing, are trapped in a debate framed by neo-liberal ideals and language, and, thus, permit these ideals to continue to frame the resistance. Mathieson supports Lakoff's critique: when the language of the dominant is used, the problem is defined within this language. As someone most interested in imagining the alternative, Mathieson adds that the more the dominant language is used, the less likely the alternative will actually differ from the status quo, making real change hard to achieve. The concepts remain and the debate is narrowed and confused.

Regardless of where one finds oneself on the continuum of this debate, it is apparent in this hearing process that the dominant framing shapes the presenters' engagement with resistance such that resistance is largely done from within. An obvious question might be: how? How is it that a certain set of discourses can come to such predominance? G. Lakoff positions his arguments in the binary of conservatives (he also refers to neo-liberalism and the right) and liberals. He argues that neo-liberalism controls the political landscape—thus the debates within them—through language. His conclusions are based on the argument that conservatives have taken concepts such as responsibility, accountability, participation, citizenship, and efficiency, which are part of

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22 Mathieson 1-36.
the dominant framing of the debates surrounding health care, defined them in ways that fit their conservative values, and then refer to them as liberal or progressive.

In the same vein, Bourdieu suggests that dominant discourses frequently consist of messages of liberation that come across as inevitable, self-evident, and hard to oppose. Examples are de-regulation, tax relief, and health reform. This language has been positioned in the public discourse by politicians, media, and others, whom Bourdieu calls active participants, such that it is has become everyday, acceptable language. The result is that these discourses are taken up by citizens—as passive participants, according to Bourdieu—and become taken for granted. While this creation of the dominant discourse is not unlike what Foucault calls the workings of government, Bourdieu’s view of passive participation appears to contradict Foucault’s concept of governmentality, which assumes an active citizen. Both are talking about how government is successful in disciplining individuals to act in line with a particular end yet the conceptualisation of citizens as passive participants or active participants deserves some exploration.

According to Hindess, “government, as Foucault describes it, aims to regulate the conduct of others or of oneself. In addition to acting directly on individual behaviour, it aims to affect behaviour indirectly by acting on the manner in which individuals regulate their own behaviour.” Foucault draws attention to the effects of practice and discourse, how they become and incorporate techniques that shape the range of actions possible and ways of being. Burchell expands, saying techniques of domination are only one side of the relationship through which governing occurs. Government, beyond just the ruling of the state, is the “contact point” between where these techniques of domination “interact” with techniques of the self which, in turn, can become integrated into “structures of coercion”. Burchell argues that techniques of the self are necessary for the existence of techniques of domination. Cruikshank says something similar: “(A)though democratic

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23 Bourdieu 29.
25 Chambon 65.
citizens are formally free, their freedom is a condition of the operationalization of power.27

One assumption of political citizenship understands government as of the people and thus, citizens have the right to participate in democratic deliberations about how they are governed. “(I)f you take power and independence from a municipality, you may have docile subjects but you will not have citizens.”28 Indeed, there is an increasing expectation to participate. Yet this participation is a form of conduct and government, from a Foucauldian perspective, is “the conduct of conduct”.29 Burchell’s notion of responsibilization originates with a discussion of the responsibility of citizens to participate and their responsibility for the outcome of their participation.30 Citizens’ participation is necessary for political power to operate. “Personal autonomy, therefore, is not antithetical to political power, but rather is part of its exercise since power operates most effectively when subjects actively participate in the process of governance.”31 There is a desire of people to participate yet this very participation is a requirement of the exercise of power.

When we are governed, when our behaviour is managed, directed or conducted by others, we do not become the passive objects of a physical determination. To govern individuals is to get them to act and to align their particular wills with ends imposed on them through constraining and facilitating models of possible actions. Government presupposes and requires the activity and freedom of the governed.32

By engaging in the discourse that has been co-opted by the embedded authorities and become dominant, to a certain extent people appear to have bought the “ends imposed on them”. People participate in their own discipline and engage with the dominant discourse willingly if not consciously. Government, in this case literally as well as figuratively, has

28 Alexis de Tocqueville in Cruikshank 19.
29 Burchell “Liberal Government and Techniques of the Self” 245.
30 Burchell “Liberal Government and Techniques of the Self” 276.
31 Peterson and Lupton 11.
requested and received the participation of individuals—the governed—and gains, through the participation of these people, legitimisation and affirmation of the consultation process. It appears, then, that contrary to Bourdieu, citizens are not passive participants but active and their active participation is necessary for governing. In this study, the dominant framing is upheld and validated by its prominence in the strategies of resistance and the counter framing.

Foucault argues that the inculcation of norms is a very effective way of controlling people. He says “(r)ather than merely forcing unwilling compliance with rules and regulations, modern institutions and societies achieve compliance by effecting changes in people through getting them to internalise promoted standards, values, and self-images.”

33 There is the construction of the standards or ideals, the construction of the veil of liberalism and desirability, and the construction of the citizen who comes to believe and act accordingly.

Cruikshank
 takes up Foucault's work on governance arguing that modes of government cannot force their interests but must enlist the willing participation of individuals in the pursuit of these interests. So, rather than denying people their rights of political citizenship, modes of government work on the “capacities of citizens to act on their own behalf”

35, getting people to govern themselves. Presenters demonstrate this self-governing: how certain programs for which they are advocating save the government money, how they take seriously their obligation to be responsible personally and for family and community members, and how citizen engagement is a serious endeavour for them. It is because they have citizenship that they take these actions that fit the agenda of the committee and the dominant framing. The strategies of resistance demonstrate how people are self-governing even as they present a counter framing, especially those within the group I labelled “Debating the Limits of the Dominant Discourse”. Presenters

34 Cruikshank 19-42.
35 Cruikshank 39.
explicate the inefficiencies in the health care system and offer suggestions of how to make it more efficient and effective. Their attempts to define and clarify definitions such as costs and responsibility sustain those concepts as paramount to the debate.

Bourdieu’s assertion of passive participation is ambiguous. To give him the benefit of the doubt, he at least acknowledges that citizens are participating. Passivity alone removes agency, capacity, possibility, freedom, and power. The co-existence of a desire of citizens to participate and the requirement of this very participation to the exercise of power looks like a bind but also presents opportunity. As Scott\textsuperscript{36} points out, even in a master–slave relationship, the slaves are far from passive participants; they know very well in what kind of power relation they exist, yet they do hold and use their power to resist. Foucault’s understanding of governmentality and Cruikshank’s view of citizenship offer a view not only of how individuals are governed and how they participate in their own governing but also, once this governance is recognised, how agency can be enacted to a different end. Neither remove nor deny agency from citizens but rather insist that there can only be power over when there is also freedom: “(p)ower [. . .] presupposes rather than annuls their capacity as agents”\textsuperscript{37}. This freedom is what makes room for, and allows for possibilities of, resistance.

In the context of these hearings, it is because people have freedom that the techniques of domination can be successful in convincing the governed of the “truth” of the dominant framing. This explanation accounts for why, even within the resistance, there are those who believe that the health care system is, for example, in a crisis and cost-effective solutions are necessary for its sustainability, even if their solutions differ drastically from those of the committee.

The counter framing of presenters resisting the dominant framing problematises privatisation and profit-making in health care and reveals much of the content and workings of the dominant framing. The presenters come from a variety of places, practices, and interests, as described so eloquently in their presentations. And while their

\textsuperscript{36} Scott 17-69.

strategies, arguments, and even values often differ, they share the underlying principle that privatisation and profit-making in our health care system is problematic, unjust, and must not escalate. The temptation to ease up on this resistance to privatisation and profit-making is really only experienced by one presenter whose co-presenter quickly rescues him from being drawn in by a question that posits profit-making (although not named as such, and thus is part of the trick) as neutral. The rest remain steadfast in their convictions.

Although some theorists suggest that speaking to the dominant framing perpetuates the dominant framing, and may even indicate an internalisation of its standards and values, presenters work hard at pushing its limits. That they so often try to re-frame and provide an alternate view illustrates they reject the normalisation of it. An essential and important discovery of this inquiry is that despite the strength of the dominant framing, the small space available for resistance, and the fact that much of the resistance is from within the dominant framing, presenters use their capacity and agency to push the limits of the dominant discourses, expose the workings of the dominant framing, and attempt to re-frame the debate. They are not passive recipients; they engage with resistance. They frequently demonstrate that they refuse the idea that privatisation and profit-making is a natural and harmless proposal for health care and offer suggestions that they believe will create an equitable and sustainable public system. The false binary of “within or without” is not lost on those engaged with resistance.

That many theorists are in disagreement about whether and how to use the language and concepts of the dominant framing leaves those of us interested in disrupting the dominant framing wondering how best to do so. There are examples in these transcripts of valiant efforts, at the least, to expose the dominant framing and its contradictions and look beyond it. As the committee narrows the debate, presenters opposed to dominant framing move to expand it beyond the fiscalisation, medicalisation, responsibilisation, and the alleged harmlessness and benignity of privatisation and profit-making in health care that permeates the dominant framing. Each strategy pushes the envelope in an attempt to push the committee beyond its increasing narrowness.

In her exploration of welfare “fraud”, Cruikshank argues that attempts to expose the “real” fraud by politicizing and making it public, regardless of its accuracy, is not an
effective mode of resistance. She might say the same about exposing the many costs of privatising health care, the contradictions in the dominant framing, and the "real" crisis. Although somewhat prescriptive, Cruikshank confirms what the presenters opposing the dominant framing of the public hearings examined in this study elucidate: that there are choices available in resistance and that, in some instances, some strategies may be more powerful than others. Some choose the technique of politeness, others sarcasm and cheekiness. Some speak with authority and demand that their expertise be taken seriously, others refuse to justify their knowledge. Cruikshank argues: "(r)esistance must take the form of a refusal to act as a recipient\textsuperscript{38}, a refusal to be what our relations to the state have made us."\textsuperscript{39}

Hoy offers yet another critique of reacting followed by an alternative way of resisting:

In reacting to domination, resistance may appear to be the act of taking a purely negative position against something, without any substantive vision of what it is for. [...] Those who are disappointed with resistance as a political activity may feel that, insofar as it is strictly reactive, it lacks a positive vision of what is to be achieved by social change. They feel that resistance stands against, not for. [...] They fear that resistance knows only how to say "no", not how to say "yes" to a different view of society that would change the status quo.\textsuperscript{40}

He argues for a critical resistance that is not merely reactive. Many of the presenters to these hearings are reacting to the dominant discourses. But many also add to their reaction constructive suggestions from a premise different than that of the dominant framing. Drawing on values, morals, language, and broad definitions\textsuperscript{41} that differ from those that constitute the dominant framing, these presenters "stand for" citizen engagement and a public health care system that is respectful of all people. Whether they completely succeed at not reacting is questionable; the pull to validate their suggestions and draw comparisons is strong, the restrictions of discourse are powerful, and the ability

\textsuperscript{38} in Cruikshank’s example, recipients of welfare
\textsuperscript{39} Cruikshank 121.
\textsuperscript{41} of health, crisis, and costs
to move outside it is difficult. Smith echoes Hoy in his work on indigenous people’s resistance and survival. Observing what he sees as a sidetrack into reactive measures, he encourages indigenous people to “set the agenda for themselves, not simply react to an agenda that has been laid out for us by others”.42 He draws from Freire in suggesting “we must name the world for ourselves”.43 Presenters are resisting the framing endorsed by the committee and putting forward their vision of a just health care system. The kind of resistance that Smith talks about takes courage and vision. The noble efforts of the presenters to resist must not be lost in the debate of whether or not to resist from within the dominant framing. Rather, their willingness to explore the options and move beyond what is presented as truth in the dominant framing and their efforts to act on their convictions combined with an understanding of how the techniques of domination operate reveal the necessity and the possibilities of resistance.

Overall, presenters reject the challenge to their understanding of participation in the public realm and demand, directly and indirectly, it be respected. Participation enables people to imagine being other than what those who govern expect and ask of us. We have the freedom to oppose, to explore, to expose, to counter and contest, to stand for, and to set the agenda. The dominant framing may shift, as the presenters to the public hearings hoped with their counter framing, or it may not; the shift may take a while to become evident; or the shift may occur for some and not others. The agency to create other realities is constructed through the act of resistance. We can choose how these modes of resistance might look and in what circumstances it is best to use the many possibilities. But we must acknowledge the possibility of resistance.

According to Munro, stories, the role they play, how and why they are told, and what they tell are significant in understanding resistance. They reveal how people construct their subjectivity, how they resist, and how they name their agency. “(S)tories revealed the limits of dominant notions of subjectivity, agency and resistance [. . .] [and]
embod(y) their vision of a more just society.”\textsuperscript{44} Following Munro’s suggestion that we re-think resistance, setting aside normative assumptions of what constitutes resistance and agency, we can consider how citizens resist on a daily basis in ways that do not fit the normative view, in keeping with Aptheker’s understanding of dailiness. Resistance is more than just possible, it is.

The binary of arguing either within or without the dominant framing is clearly a contested one. Sandoval offers a perspective markedly different than those who come down on one side of the debate or the other, sometimes adamantly. In her in-depth theorising of “methodology of the oppressed”, she imagines a way to consider many angles at the same time.\textsuperscript{45} Her thinking on social movements is developed by examining Althusser’s theory of “ideology and the ideological state apparatuses”\textsuperscript{46}. She describes her experience with the Civil Rights Movement as representative of social movements that were waning because of internal debates over strategies of opposition, debates that remain active today. Althusser outlines the principles by which citizens “are called into being as citizen/subjects who act – even when in resistance – in order to sustain and reinforce the dominant social order”, thinking in line with where Foucault and others originated. Althusser begins to propose that citizens in opposition are able to contest and alter “the current hierarchical nature of the social order”.\textsuperscript{47} Wanting to go further with this idea, Sandoval builds on his work by developing a theory of ideology that focuses on identifying forms of consciousness in opposition by those wanting to oppose the dominant social order. Her goal is for citizens\textsuperscript{48} to learn to identify, develop, and control the means of ideology necessary to “break with ideology” while also speaking in and from within it: speaking against it and within it. Using the analogy of a clutch to engage

\begin{itemize}
  \item \textsuperscript{44} Petra Munro, \textit{Subject to Fiction: Women Teachers’ Life History Narratives and the Cultural Politics of Resistance} (Buckingham: Open University Press, 1998) 111.
  \item \textsuperscript{45} Chela Sandoval, \textit{Methodology of the Oppressed}, (Minneapolis, MN: University of Minnesota Press, 2000)
  \item \textsuperscript{46} Chela Sandoval, “U.S. Third World Feminism” The Theory and Method of Oppositional Consciousness in the Postmodern World” \textit{Genders} 10 (Spring 1991) 1-24.
  \item \textsuperscript{47} Sandoval, “U.S. Third World Feminism” 2.
  \item \textsuperscript{48} Sandoval refers to subject-citizens.
\end{itemize}
gears in a car, Sandoval speaks of a differential consciousness that permits a new kind of transmission of power:

(It) enables movement ‘between and among’ the other [. . .] modes of oppositional consciousness considered as variables, in order to disclose the distinctions among them. In this sense the differential mode of consciousness operates like the clutch of an automobile: the mechanism that permits the drive to select, engage, and disengage gears in a system for the transmission of power.49

Sandoval continues her thinking as she analyses the work of Barthes. Barthes lists the “oppositional” or “anti-languages” that counteract the weight of what I am calling the dominant framing but posits that none will be as effective as another kind of language or technology of resistance, “meta-ideologizing”50. “This challenge to dominant cultural forms best occurs [. . .] not by speaking outside their terms [. . .] nor through manifestly setting new terms linked to the real [. . .] but through the ideologization of ideology itself.”51 This resistant language functions both within and against ideology, attaching a “third level ideological system onto a dominant second-level system” to challenge the dominant order of power.52 Sandoval paraphrases Barthes: “‘Truth to tell, the best weapon against’ ideology is to ideologize it in its turn, and to produce an ‘artificial’ ideology.”53 According to Sandoval, this strategy can either expose “the original dominant ideology as naïve – and no longer natural54 or to reveal, transform, or disempower its signification in some other way”. Differential oppositional consciousness is not unlike engaging different gears for different road conditions while the “ideologization of ideology”, then, becomes the clutch to obtain the correct gear for a particular situation or audience.

Sandoval’s proposals endeavour to remove the debate from the binary rigidity that accompanies the “within or without” debate that so many other theorists argue. A couple

49 Sandoval “U.S. Third World Feminism” 14.
50 Sandoval, Methodology of the Oppressed 108-109.
51 Sandoval 109.
52 Sandoval 109. Italics in original.
53 Sandoval, Methodology of the Oppressed 109. Italics in original.
54 I would add or neutral or harmless.
of the presenters to the public hearings appear to make efforts to move in this direction. For example, those who expose the workings of the dominant framing attempt this "ideologization of ideology". One presenter in particular focuses most of his presentation on telling the committee and those attending the hearing how he sees that the dominant discourse is constructed so as to convince citizens that the system is in crisis with the purpose of proposing privatisation as the solution. He exposes and names the ideologies and in doing so, even if for a moment and even if for a few people, he renders this dominance a little less powerful. Both of Sandoval's theoretical approaches to resistance are complex and need some work to translate them into practical applications and make them accessible. However, they attempt to deal with a longstanding debate, freeing up a way to consider resisting both "within and without", adding force to the resistance.

Summary

In these public hearings, presenters do speak to the dominant discourses and framing of the debate, in part, because that is how effective framing can work. This strategy is also the effect of discourse. However, many of the concepts that constitute the dominant discourses and framing are appealing to most people, they resonate with us, and are present inside us. They are not, at face value, objectionable. Therefore, it is not enough to say that because these presenters resist from within the dominant framing, they have necessarily been coerced or indoctrinated. Such an analysis may be too simplistic and dismissive. That is not to say, however, that there is not much to learn about how to resist in particular situations and how to consider resisting in a way that avoids the binaries that typically guide our strategies of resistance.

Aptheker would likely posit that the very engagement of these presenters in this process and their willingness to speak are, in themselves, resistance. The time, thought, and energy to prepare their presentation, their written submissions where relevant, and their presence at the hearings are acts of resistance. Their presence is also indicative of their shared understandings of citizenship. A frequent claim of legitimising processes such as public consultations is that they are progressive and democratic, reducing the

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55 It is not possible to know with certainty which people making oral presentations at the hearings also submitted written submissions; some referred to them and others did not but may have had them there.
power relations by sharing the power amongst all who participate. Presenters enter the process with this understanding and take to heart their role and their right as citizens, including those who contest the dominant framing.

A critical look at this particular public consultation process reveals the effects of power relations on participation and, thus, resistance. To a certain extent, these presenters are also participating in the dominant framing. But they are doing so at the same time as they are resisting. This point is not made to discourage involvement or to discredit all similar processes. For those who do choose this type of forum to enact their political citizenship, it is helpful to understand how their involvement will be shaped by discourse and power relations. We need to question the assumption of democracy, which is not to question that all citizens have the right to participate in shaping the conditions of their lives. Understanding how we are regulated may offer us the option of considering other ways of participating.

Peterson and Lupton put forward another possibility: “Faced with the imperatives associated with being a responsible, active citizen, individuals can perhaps most effectively assert their agency and autonomy by simply not engaging with those processes that attempt to regulate them.” They are not prescribing non-engagement but are putting it forward as an option to consider. The risk, however, may be that with no opposition brought to the table, the only voices speaking to privatisation and profit-making in health care would be of those in support. Given a general assumption that consultation processes allow for the voices of citizens to be heard, the committee could say with confidence that they did hear from citizens and conclude that, indeed, there is a financial crisis and privatisation and profit-making were endorsed as the solution.

The fact that the presenters who resisted the dominant framing to these public hearings affected more than just the committee to whom they presented is an invaluable contribution. There are a plurality of publics and a plurality of discursive spaces and contesting discourses allowing for the consideration of other venues and formats of political participation and resistance. Although the BC Select Standing Committee on Health and the legislature may have been their target audience, it is important to note that

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50 Peterson and Lupton 162.
these presenters have a greater audience than the members of the committee who were attending the hearings. Beyond the committee are the other citizens who attended the hearings either because they had a presentation time slot that same day or because they were interested in the proceedings. I fit into the latter category, attending for a couple of hours because I was curious about what the presenters had to say, how the committee would respond, and how the hearings were structured. But the audience extends beyond those physically in attendance. I became one of multiple audiences. This thesis also bears witness and those who read it will join the audience. The discussions that take place beyond the purview of the hearings, generated prior to and from the presentations, take the resistance outside the place and time of the hearings and draw in new players. The site of the public hearings was chosen for this inquiry. The resistance witnessed in the hearings did not stop there nor is limited to that one site.

Further still is the audience of *Hansard*, a written record of the hearing proceedings available for all who want to and are able to access it, present and future. It is this idea of the future that holds particular interest: I am able to delve into my inquiry and present what I find in the transcripts because they are on permanent record. I was not only an audience at a hearing, I became an audience as I read, downloaded, and read again the transcripts well after the real time of the hearings.

Aptheker argues that resistance does not always appear to be oppositional. Walking in and out of the front door and saving for an education combines the affirmation of life today and hope for the future. It may take years or even decades before a child from a village or family attends university, so to it may take years before the ideas of resistance against privatisation and profit-making in health care take hold. Resistance is not just for the moment. This thesis captures some of this resistance with the hopes that it will see its goal someday, if not now. Bourdieu says “it takes time for something false to become self-evident”\(^{58}\). Conversely, it takes time, repetition, and multiple audiences for those in resistance to contest the falseness and speak their truth.

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\(^{57}\) Aptheker 167-230.

\(^{58}\) Bourdieu 30.
Not only am I impressed with the amount and kinds of resistance despite the small and uncomfortable space, I have learned a great deal from the presenters about the many ways privatisation and profit-making are understood and experienced. My own aversion to privatisation drew me to this thesis. I have come from the standpoint of a healthy person with an intellectual understanding of the injustice of privatisation and a sense of its impact on people's lives. The presentations of resistance, especially the stories therein, provide powerful illustrations of human experience that convince me more than ever that our public health care system can—and must—be maintained and improved.
Chapter 8: Conclusion

Changes in health care are often linked to trends such as a shifting population, new technology, and varying financial and social priorities. Changes are also influenced by politics—local and global, our relationships with other countries, trade agreements and organisations, and corporate agendas. Most certainly, the future of health care is an important issue for Canadians.

Privatisation in health care is expanding in Canada; it is increasingly positioned by its proponents as not only logical, but necessary for Canadians to receive quality and timely health care. Yet polls suggest that Canadians want to maintain a public system. This incongruence led to my interest about the location and expression of resistance to privatisation and to this inquiry. To locate and understand resistance to the privatisation of health care, it was important to first understand how privatisation and profit-making have come to such a place of prominence in current debates. An opportunity to delve into these interests presented itself with the election of a new provincial government in British Columbia and the launch of a public consultation process whereby citizens could participate in determining the future direction of health care in B.C. The purpose of this study was to explore a public consultation process to identify the framing of the debates within health care and examine citizen engagement with resistance to the privatisation of health care.

Research is rarely a linear process and this inquiry is no exception. The questions I asked became clear in the answering:

What are the discourses currently framing the debate around health care and how do these discourses operate? What strategies are used to invoke these discourses and framings?

How do citizens engage in opposition within this framing? What are the strategies for opposition? Is there a relationship between framing health care in particular ways and the possibilities for being a citizen and for opposing?

The purpose of this study and its research questions are important to understand how debates get framed and taken up in particular ways and to consider possibilities of
resistance. The methodological approach of critical discourse analysis allowed me to see the social practice of discourse in production and the resulting knowledge in both the dominant and counter framings of the debate. The benefit is that once particular practices and productions of knowledge are exposed, it is possible not only to imagine contesting them, but to actually engage in acts of resistance that offer alternative knowledges and practices; this thesis contributes to this effort. It is an act of resistance.

This examination of the public consultation process by the BC Select Standing Committee on Health revealed the discursive strategies used to create the dominant framing and to narrow and put limits on the debate. Analysis exposed the constriction of space for discussion to one of fiscalisation, medicalisation, responsibilisation where the discourses of responsibility, sustainability, costs, and crisis dominate and privatisation is positioned as harmless and necessary. It is in this narrowing that meanings and particular knowledges were produced and maintained. Participation in this small space required a focus on the problems approved and identified in the dominant framing to be listened to by the committee. Specific strategies were employed to keep the debate confined.

In this constricted space, resistance was, nevertheless, evident. The five distinct groupings for strategies show us how citizens attempted to contest the dominant framing and create a counter framing. Through a critical analytic process, I was able to pull out these strategies from the presentations:

- claiming authority and citizenship,
- setting the tone and establishing a relationship,
- debating the limits of the dominant discourse,
- exposing the manufacturing of the dominant framing and re-politicising the debate, and
- attempting to start with a different premise.

These strategies also create important knowledge by exposing the creation of meaning in the dominant framing and by attempting to obstruct its dominance and create meaning of their own.

Strategies to counter the dominant framing are as discursive as are the strategies of the dominant framing. Many of the same discourses and the concepts and language that constitute those discourses are shared and drawn upon by both framings. This insight is helpful; resisters can determine for themselves how useful it is to draw on the dominant
discourse when engaging in resistance. As we understand how discourse operates, we can learn to locate the spaces, however small, within which we can resist and we can be strategic in our discursive approaches to support our resistance. By drawing out the strategies from the presentations and making them evident, I have put them on the table for consideration in future resistance. Some ways to resist may be more appropriate in some contexts, but there is no right or wrong way to resist. The findings of this study show just how diverse and varied resistance can be and opens up the possibilities of what can be accomplished, even in a small space.

This research adds to the body of knowledge of resistance. Part of its contribution is as simple as providing examples of some “how to’s”. But perhaps as crucial is a finding that is more complex than what the resistance looked like. This study goes further by shedding light on how resistance is shaped and framed by dominant discourses and by its own strategies to create a counter framing. Foucault’s understanding of governmentality and Cruikshank’s view of citizenship offer a view not only of how we are governed and dominated but how we participate in our own governing and dominance. This discovery is palpable in this research. The “us” and them” are not so distinct. Once this governance is recognised, however, we can consider how to enact our agency and citizenship to a different end, an important insight gained from the research. As Burchell says “there is also the need to invent other possible practicable alternative forms of governing others and ourselves, the need for an equal effort of experimentation”.

There will always be issues, policies, practices, and debates that offend, prejudice, and pose harm to people. For those who seek peace, equality, human rights, and social justice, in the world and in their lives, resistance is a way of life. This research contributes to a framework of understanding how to imagine and consider engaging with resistance in the inevitable structures of power relations. I am now aware of how I inadvertently contributed to the dominant framing in my past attempts at resistance. As I consider future involvement with political and social actions, I see how I might reconsider my actions and how I might use certain strategies for particular ends. In fact,

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my passion has been invigorated by what I have learned as I have a better grasp on how things work. While situated in the context of health care because it is an issue close to my heart, the knowledge gained in this research is applicable to many other issues and situations.

These findings were made possible by an approach to research that is unique amongst most research into public consultation. Rather than being retrospective, my inquiry led me to the “in the midst” of participation, where I looked at the immediate influences on and shaping of resistance as it happened. This approach, facilitated by the methodology of critical discourse analysis, allowed me to see discourse in production and reproduction, useful information to take in to such a process and helped to answer my research questions.

I have claimed to use as data the transcripts of all the presenters who opposed, in a substantial way, privatisation and profit-making in health care in this public consultation process. A limitation to my method is that there may have been other presenters who were in opposition but their opposition to privatisation and profit-making was not a significant component of their presentation. I set purposeful parameters in my method so as to have substantial examples of resistance. The existence of other resisters does not take away from the value of this research as, indeed, the findings were rich.

I have not attempted to solve the long-standing debates that exist about how best to engage with resistance. Readers are invited to make their own judgements and draw their own conclusions about what they think works and what does not, and where certain strategies may be more successful than others; there are no set answers. Sandoval provides us with other ways to consider resistance. Her writing is very theoretical and her suggestions are difficult to access. The vast majority of people engaged in resistance are not going to read Sandoval and then have immediate insight into what they might want to consider the next time. Her theories need to be written in accessible language and articulated in the context of practical examples to be useful beyond the theoretical level.

Was the resistance in this study successful? I suggest that question is impossible to answer. How does one define or measure success? There is no time limit to success; it can take days or decades. Perhaps future research could explore the concept of success resistance, or effective resistance especially in the context of dominant framing. In
addition, further research might consider strategies of resistance given our understanding of our participating in our own governance.

The continuum of sites of resistance ranges from activities of dailiness to armed mass rebellion. The strategies of resistance that emerge in this study are examples of practical applications of many theories in a particular, tightly controlled, local setting. We saw indications of daily acts of resistance in people's stories. Underneath their politeness and thoughtfulness (strategies in themselves), however, was anger and fear. There are examples of more forceful strategies of resistance in Canada and one need not look too far to understand why some people in some countries consider resistance as extreme as uprising or insurgency as their only choice of resistance. One might ponder: are there always choices in the ways we can resist? When is the time and where is the place for forceful strategies of resistance? Furthermore, what role does or should ethics play in determining resistance? Should resistance be guided, or limited, by ethical considerations, any more or less than the practices and effects of dominant discourses and those in ruling positions?

What is clear from this research is that resistance is not easy work. On one hand, this information is reassuring; many people think their efforts are often in vain and a waste of time or they just do not get how to do it and be “successful”. While understandable, to be so discouraged is to give up power and, more importantly, give up possibilities and hope. Results are not readily evident. This work is hard but for those seeking social justice, it is necessary. Knowing what contributes to the difficulty of engaging with resistance will only enhance further efforts. Countering the dominant framing was not easy for presenters to the BC Select Standing Committee on Health. This research sheds light on why.

Finally, it is important to come back to the issue that brought me to this study: privatisation and profit-making in health care. The presenters in this study have taught me about the many ways privatisation is understood and experienced. They brought the sobering facts of everyday essential reality into the debate. Their presentations substantiate the arguments against privatisation and profit-making in health care in Canada. I am more convinced than ever that this issue is one of social justice and I have confirmed my belief that it must be resisted.
Afterword: Post Script to Hearings

In December, 2001, immediately following this legislative consultation, the BC Select Standing Committee on Health produced a report entitled *Patients First: Renewal and Reform of British Columbia's Health Care System*. The section “Setting the Context” is focused on the finances of health care, maintaining the dominant framing through such statements as “the health care system seems on the verge of collapse”. The multiple recommendations the committee makes to the government are worthy of their own study.

Within weeks of the publication of this report, services such as physical therapy, optometry, and massage therapy were de-listed from Medical Services Plan (MSP), user fees for other services were increased, and MSP premiums were increased by 50 percent. In some health regions, a number of long term beds were closed down in favour of assisted living beds, the majority of which are privately owned and operated for profit. Several health regions in the province have contracted out services such as housekeeping, laundry, and dietary services in health care facilities to private for-profit contractors, citing the need to meet the budget.

Just as this thesis goes to print, the B.C. provincial government passed legislation that allowed for the contracting out of Medical Services Branch and Pharmacare services to an American profit-making company despite allegations that personal information could be accessed by the FBI in the United States under their Patriot Act. Additionally, St. Paul's Hospital in Vancouver is shutting down three operating rooms and temporarily contracting out 980 day surgeries to private clinics allegedly because of a shortage of nurses. The Vancouver Island Health Authority has taken a similar measure. The Minister of Health has supported these moves as a temporary measure that he says will ensure patient care.

To the presenters who opposed the dominant framing and created a counter frame at the public hearings of the BC Select Standing Committee on Health, these kinds of changes represent increased privatisation and profit-making and the fears they speak to in their presentations.
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University of Victoria - Human Research Ethics Committee

Certificate of Approval of Waiver

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Project No. Approval Date Start Date End Date
016-03 28-Jan-03 28-Jan-03 27-Jan-04

Certification

This is to certify that the University of Victoria Ethics Review Committee on Research and other Activities Involving Human Subjects has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

J. Howard Brunt
Associate Vice-President, Research

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